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No.

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

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QUESTION PRESENTED

Whether the Court of Claims has jurisdiction under 28 U.S.C. 1491 to review administrative determinations of the amount of benefits payable under Part B of the Medicare Act, 42 U.S.C. 1395j *et seq.*

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UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

The Solicitor General, on behalf of the United States, petitions for a writ of certiorari to review the judgment of the United States Court of Claims in this case.

OPINION BELOW

The opinion of the Court of Claims (App. A, *infra*, 1a-28a) is reported at 634 F.2d 580. The decisions of the insurance carrier's hearing officer on respondent's claims under Counts I and II of the Supplemental Petition (App. D, *infra*, 34a-50a), the hearing officer's denial of respondent's request to reopen the hearing and reconsider that decision (App. E, *infra*, 51a-52a), and the hearing officer's decision on respondent's claims under Count III of its Supplemental Petition (App. F, *infra*, 53a-88a) are not reported.

JURISDICTION

The opinion of the Court of Claims was issued on October 22, 1980. An order removing the case from the Court of Claims' docket (App. B, *infra*, 29a) was en-

tered on October 24, 1980. The order on the government's motion for rehearing, clarifying aspects of the court's opinion (App. C, *infra*, 30a-33a), was entered on February 6, 1981. On January 12, 1981, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including March 21, 1981. The jurisdiction of this Court is invoked under 28 U.S.C. 1255(1).

STATUTES INVOLVED

1. Section 1869 of the Social Security Act, 42 U.S.C. 1395ff, provides in pertinent part:

> (a) Entitlement to and amount of benefits.
>
> The determination of whether an individual is entitled to benefits under Part A or Part B, and the determinations of the amount of benefits under Part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) Appeal by individuals.
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or section 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of Part B of this subchapter, or section 1395i-2 of this title, or section 1819, or
>
> (C) the amount of benefits under Part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such

subparagraph (C) if the amount in controversy is less than $1,000.

2. Section 205(h) of the Social Security Act, incorporated into the Medicare Act through 42 U.S.C. 1395ii and codified at 42 U.S.C. (1970 ed.) 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.[1]

3. 28 U.S.C. (& Supp. III) 1491 provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort.
>
> * * * * *
>
> To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or

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[1] In the 1976 edition of the United States Code, which has not been enacted into positive law, the third sentence of Section 205(h) is changed to refer to "sections 1331 and 1346" of Title 28 rather than "section 41 of title 28," as in the Social Security Act itself.

official with such direction as it may deem proper and just.

STATEMENT

The issue in this case is whether the Court of Claims has jurisdiction under 28 U.S.C. (& Supp. III) 1491 to review the amount of benefits payable under Part B of the Health Insurance for the Aged and Disabled Act (commonly known as the Medicare Act), 42 U.S.C. 1395j *et seq.*, for particular medical and other health services. Before relating the facts of this case, we shall briefly describe the Medicare program and the provisions for administrative and judicial review of certain determinations made under the Act.

1.a. The Medicare program is divided into two parts. Part A of the Act, 42 U.S.C. (& Supp. III) 1395c to 1395i-2, provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) 1395c and 1395d. Payment for these services is made directly to the hospital or other provider of services. 42 U.S.C. 1395g. The amount of benefits payable to the provider is to be determined by the Secretary of Health and Human Services (HHS), 42 U.S.C. 1395f, 1395g and 1395x(u), although the Secretary is authorized to enter into a contract with a fiscal intermediary nominated by the provider, under which the intermediary will determine the amount of payments due and make these payments to the provider. 42 U.S.C. (& Supp. III) 1395h.

Part B of the Medicare Act provides a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable costs of certain other medical services—primarily physicians' services and such items as medical supplies, x-rays and laboratory tests. 42 U.S.C. (& Supp. III) 1395k and 1395*l*. Part B benefits are administered by insurance carriers pursuant to contracts entered into with the Secretary. 42 U.S.C. 1395u. The carrier determines the amount required to be paid under Part B and pays the benefit, generally either to the individual insured or to the physician or other supplier of services to whom the insured has assigned his benefits. 42 U.S.C. 1395u(a)(1)(A) and (B), 1395u(b)(3)(B).

b. The Medicare Act provides specific mechanisms for review of certain determinations made under the Act. Pursuant to 42 U.S.C. 1395ff, the Secretary must determine whether an individual is eligible for any benefits under Part A or Part B. If an individual is dissatisfied with the initial determination that he is ineligible for benefits, he is entitled under 42 U.S.C. 1395ff(b) to a hearing on that question by the Secretary as provided in 42 U.S.C. 405(b) and to judicial review of the Secretary's final decision as provided in 42 U.S.C. 405(g).

The Act also directs the Secretary to determine the amount of benefits under Part A (see 42 U.S.C. 1395ff(a); 42 C.F.R. 405.704(a)), although, as noted above, this determination is ordinarily made by a fiscal intermediary. 42 U.S.C. (& Supp. III) 1395h. If the individual beneficiary is dissatisfied with the determination regarding the amount of benefits to which he is entitled under Part A, the Act grants a right to a hearing by the Secretary under 42 U.S.C. 405(b) where the amount in controversy is $100 or more and a right of judicial review under 42 U.S.C. 405(g) where the amount in controversy is $1,000 or more. Review is expressly barred where these amount-in-controversy requirements are not satisfied. 42 U.S.C. 1395ff(b)(2). See also 42 U.S.C. 1395pp(d).

In addition to these rights of review at the behest of the individual beneficiary, a hospital or other provider of Part A services also has a right under 42 U.S.C. 1395*oo*[2] to obtain review of the total amount of reimbursements to which it is entitled for all services rendered during a particular year. That section states that if a provider is dissatisfied with the fiscal intermediary's determination, after reviewing the provider's annual cost report,[3] as to the total amount of reimbursement, and if the amount in controversy is at least $10,000, the provider is entitled to

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[2] This section was added to the Act in 1972. Pub. L. No. 92-603, Section 243(a), 86 Stat. 1420.

[3] See 42 U.S.C. 1395*oo*(a); 42 C.F.R. 405.406(b) (1979).

a hearing before a Provider Reimbursement Review Board composed of five members appointed by the Secretary. The provider may obtain judicial review in district court of an adverse decision by the Board. 42 U.S.C. 1395*oo*(a) and (f). The Act contains no mechanism for judicial review of reimbursement determinations under Part A where the amount in controversy is less than $10,000.

The Act contains far more limited provisions for review of determinations made under Part B. Whether any benefits are payable under Part B of the Medicare Act for a particular service and the amount of such benefits are determined by the insurance carrier, not by the Secretary. 42 U.S.C. 1395u(a). The only provision for review of the carrier's determination is contained in 42 U.S.C. 1395u(b)(3)(C), which states that the Secretary's contract with the carrier must provide that an individual enrolled under Part B will have "an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more * * *." In contrast to benefit amount determinations under Part A, the Act does not provide for the Secretary or an appeals board to review benefit amount determinations by a carrier under Part B or grant the individual beneficiary a right of judicial review of such determinations. A physician or other person who furnishes supplies or services to an individual insured under Part B and accepts an assignment from that individual has the same right of review, including a hearing by the carrier, as the individual. 42 C.F.R. 405.801(a). But the Act does not grant the physician or other supplier under Part B an independent right to have the carrier's determination reviewed by the Secretary or a court. Compare 42 U.S.C. 1395*oo*.

Finally, by virtue of 42 U.S.C. 1395ii, the provisions of Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), precluding review of findings and decisions by the Secretary except as provided in the Social Security Act itself (see page 3, *supra*), are expressly made applicable to the Medicare Act.

2. Respondent Erika, Inc. is a distributor of medical supplies used by patients undergoing kidney maintenance dialysis. Its customers include a large number of beneficiaries under Part B of the Medicare program. The Prudential Insurance Company was designated by the Secretary as the insurance carrier for the processing of Part B claims in New Jersey, where respondent's business is based. As the carrier, Prudential was responsible for determining the "reasonable charge" for supplies furnished by respondent to Part B beneficiaries, 42 U.S.C. 1395u(a)(1)(A), 80% of which would then be paid by the Medicare program, 42 U.S.C. (& Supp. III) 1395*l*. In determining the "reasonable charge" for Part B services, the carrier must take into account both the customary charge generally made by the particular person who furnished the Part B services and the prevailing charge made by all persons in the particular locality for similar services. 42 U.S.C. (& Supp. III) 1935u(b)(3). For each year involved in this lawsuit, a supplier's "reasonable charge" could not exceed the prevailing charge level that the carrier determined would cover 75% of all customary charges made for similar services in that locality during the calendar year preceding the 12-month period (beginning July 1 of each year) in which the bill was submitted. *Ibid.*[4]

Respondent's prices, which applied to both Medicare and non-Medicare sales, were listed in an annual catalogue effective July 1 of each year and in catalogue supplements issued during the succeeding twelve months to reflect price changes. Because respondent's sales accounted for almost all of the sales of the relevant supplies in the locality, Prudential utilized respondent's sales price for a particular product to fix the prevailing charge level that respondent's "reasonable charge" for that product could not exceed. As a result, the "reason-

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[4] This provision was amended in December 1980 by Section 946 of Pub. L. No. 96-499, 94 Stat. 2642.

able charges" for respondent's supplies in the 12-month period beginning July 1, 1975, were those listed in its July 1974 catalogue. Prudential did not increase respondent's "reasonable charges" to take into account intervening price increases.

When respondent sold its dialysis supplies to Part B beneficiaries, it received assignments of claims from the beneficiaries and submitted invoices to Prudential based on the prices in effect at the time of sale. Prudential reimbursed respondent, however, on the basis of the catalogue prices in effect on July 1 of the preceding calendar year. Respondent alleged (Supp. Pet. ¶ 45; see also *id.* at ¶¶ 29, 65) that it did not discover that Prudential had been making payments based on respondent's July 1, 1974 catalogue prices until early 1976. Respondent then requested that Prudential adjust the amounts of past and future payments to reflect intervening price increases. Pursuant to Section 5010.2 of HHS's Carriers Manual (App. F, *infra*, 69a), which allows for adjustments in the amount of customary charges in highly unusual situations where equity clearly warrants, Prudential made an adjustment, effective May 26, 1976, for sales of the drug heparin. But Prudential declined to make a retroactive adjustment for past sales of that drug, concluding that it had no authority to do so (App. A, *infra*, 5a-6a). For the other products involved in this case, Prudential declined to make any of the requested adjustments. Prudential's initial determinations were affirmed following the "fair hearing by the carrier" required by 42 U.S.C. 1395u(b)(3)(C).

3.a. Following the decision by Prudential's hearing officer, respondent filed this lawsuit in the Court of Claims, contending that Prudential's action was inconsistent with the Medicare Act, violated the due process and equal protection guarantees of the Fifth Amendment, and resulted in a taking of its property.

On cross-motions for summary judgment, the Court of Claims rejected the government's argument that the court lacked jurisdiction to decide respondent's reimbursement

claims. The Court of Claims held (App. A, *infra*, 6a-7a) that, on its face, respondent's contention that Prudential's refusal to account for its interim price increases violated the Fifth Amendment, the Social Security Act, and implementing regulations fell within the court's jurisdiction under the Tucker Act, 28 U.S.C. 1491. Moreover, the court rejected the argument that a congressional intent not to subject a carrier's Part B benefit determinations to judicial review was demonstrated by the fact that, in 42 U.S.C. 1395ff, Congress had expressly provided the individual beneficiary with a right of judicial review of his eligibility for and the amount of benefits under Part A, but had limited the right of judicial review under Part B to questions of the individual's eligibility for benefits. The court interpreted 42 U.S.C. 1395ff as establishing only the particular procedures to be utilized in obtaining judicial review, not as limiting the availability of such review (App. A, *infra*, 10a-11a, quoting *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), cert. denied, 430 U.S.C. 969 (1977)):

> Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional guidelines.

In the court's view (App. A, *infra*, 11a), 28 U.S.C. 1491 is such a general jurisdictional provision for judicial review in the Court of Claims.

The court declined to attach significance to a passage in the Senate Report stating that the Act "does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A" (S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965)) and a similar statement made during floor con-

sideration of the 1972 amendments to 42 U.S.C. 1395ff that "[t]he situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters" (118 Cong. Rec. 33992 (1972)). The court acknowledged that these statements reflected an intent to bar claims challenging the amount of reimbursement allowed in particular instances—"as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services" (App. A, *infra*, 14a). But this purpose to bar a flood of small claims would not be thwarted, the court reasoned, "by permitting judicial review of contentions that particular benefit determinations violated constitutional or statutory provisions. For once a particular contention of that kind had been adjudicated, that issue would be settled, and there would be no occasion for further litigation of the point" (*id.* at 14a-15a). Accordingly, the court did not find the statements in the legislative history to be "clear and convincing" evidence of a congressional intent to preclude judicial review of Part B determinations (*id.* at 14a).

b. On the merits, the Court of Claims found that Prudential had violated the requirement in 42 U.S.C. (& Supp. III) 1395u(b)(3) that the prevailing charge level for the 12-month period beginning July 1 of each year be calculated on the basis of charges in the locality "*during* the last preceding calendar year" (App. A, *infra*, 15a-16a) (emphasis added) by looking to the respondent's catalogue charges in effect on July 1 of that year. According to the court, Prudential was required to take into account prices charged before July 1, which may have been lower than the catalogue price, as well as any price increases effective later in the calendar year. The court therefore remanded the case to Prudential to redetermine respondent's reasonable charges in accordance with its opinion, using such method of cal-

culation as Prudential in its discretion deemed appropriate (App. A, *infra*, 22a).[5]

With respect to the drug heparin, the court determined (App. A, *infra*, 19a-21a) that Prudential's hearing officer had erred in relying solely upon a particular HHS directive in deciding that it could not make a retroactive adjustment in the charges allowed because, in the court's view, that directive had become obsolete. It therefore remanded this aspect of the case to Prudential as well to determine whether a retroactive adjustment should or could be made under whatever other standards and policies the Secretary had promulgated.[6]

Finally, the court found "insubstantial" respondent's claim that Prudential's failure to reimburse it on the basis of its current charges, rather than prevailing charge levels in the preceding calendar year, denied it due process and equal protection (App. A, *infra*, 22a). The court found it reasonable for Congress, "in order to control Medicare costs and to provide an orderly system for administering this vast and complex program, to base reim-

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[5] Respondent did not challenge Prudential's determination on this ground in its "fair hearing" conducted by Prudential or in the Court of Claims, perhaps because Section 5010.1 of the Carriers Manual (App. G, *infra*, 89a-90a) expressly allows a carrier to utilize a price list in effect at the midpoint of the calendar year in calculating a supplier's customary charges if the carrier does not have adequate statistics on prices charged by the supplier throughout the year. The court's order on the government's petition for rehearing (App. C, *infra*, 30a-33a) made clear that the validity of Section 5010.1 of the Carriers Manual had not been determined.

[6] The court rejected respondent's argument that Prudential should have adjusted respondent's "reasonable charges" for supplies other than heparin to take increased prices into account. The court observed (App. A, *infra*, 21a) that the determination whether to grant an adjustment and permit a departure from prevailing charges for the preceding calendar year "is within the discretion of the carrier," and it concluded that it could not "direct Prudential whether or how to exercise that discretion in a particular case" (*ibid.*).

bursement on charges made during the prior year" (App. A, *infra*, 22a).

REASONS FOR GRANTING THE PETITION

The availability of judicial review of determinations under the Medicare Act is an important and recurring issue on which the lower courts have taken divergent positions and which warrants review by this Court. Review is especially appropriate in the instant case, because the Court of Claims has held that it is empowered to review individual benefit determinations by insurance carriers under Part B of the Act. The text and legislative history make clear that Congress deliberately foreclosed judicial review of such determinations, which typically involve relatively small amounts of money.

1. The Court of Claims' assumption of jurisdiction under 28 U.S.C. (& Supp. III) 1491 to review determinations by insurance carriers of the amount of benefits payable for a particular service under Part B of the Medicare Act is inconsistent with Congress' clearly expressed intention to preclude judicial review of those very determinations. As the Court of Claims recognized (App. A, *infra*, 19a), respondent's right to obtain reimbursement from Prudential for its sales of equipment and supplies to Part B beneficiaries derives solely from the beneficiaries' assignment to respondent of their individual reimbursement claims. Accordingly, respondent, as assignee of thousands of separate claims under Part B, may exercise only those rights of review enjoyed by the individual beneficiaries under the Act. 42 C.F.R. 405.801(a); *Szekely* v. *Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975), cert denied, 425 U.S. 960 (1976).

As explained above, 42 U.S.C. 1395ff provides an individual beneficiary with a right to a hearing before the Secretary and subsequent judicial review only with respect to the Secretary's determination of his *eligibility* for Part B benefits. The Act assigns the responsibility for making decisions on the *amount* of benefits payable for

a particular service under Part B not to the Secretary, but to insurance carriers that are experienced in determining reasonable and customary charges for medical services in the particular locality by virtue of their insurance business in the private sector. S. Rep. No. 404, 89th Cong., 1st Sess. 53-54 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 46 (1965). Where the beneficiary wishes to dispute the carrier's initial benefit determination, the Act requires only that he be given "an opportunity for a fair hearing *by the carrier*" (42 U.S.C. 1395u(b)(3)(C); emphasis added). The statute makes no provision for a hearing by the Secretary or subsequent judicial review. Because, with respect to Part A benefit determinations, Congress *expressly* provided for a hearing by the Secretary where the amount in controversy is at least $100 and a right of judicial review where the amount in controversy is at least $1,000, 42 U.S.C. 1395ff(b)(2), traditional principles of statutory construction compel the conclusion that Congress' omission of comparable procedures under Part B was deliberate. *Fedorenko* v. *United States*, No. 79-5602 (Jan. 21, 1981), slip op. 20-21.

The legislative history of the Medicare Act confirms that Congress intended to preclude judicial review of benefit determinations under Part B. The Senate Report on the 1965 Act states:

> Hearings and judicial review are * * * provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the amount in controversy is $1,000 or more. (*Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.*) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination

> regarding their eligibility to participate in the program. *It is intended that the remedies provided by these review procedures shall be exclusive.*

S. Rep. No. 404, *supra*, at 54-55 (emphasis added); see also H.R. Rep. No. 213, *supra*, at 47. Thus, as the last quoted sentence makes clear, the designated remedy for complaints regarding the *amount* of benefits under Part B—review by the carrier, not the Secretary, and without a right of judicial review—was plainly intended to be "exclusive."

This conclusion is evident as well from the incorporation into the Medicare Act, through 42 U.S.C. 1395ii, of Section 205(h) of the Social Security Act, 42 U.S.C. 405(h). The first two sentences of Section 205(h) provide (emphasis added):

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.

Because the carrier acts on behalf of the Secretary in making benefit determinations (S. Rep. No. 404, *supra*, at 54), the carrier's findings and decision are binding upon the parties to the "fair hearing by the carrier" provided by 42 U.S.C. 1395u(b)(3)(C), and they cannot be reviewed "by any person, *tribunal* or governmental agency" (emphasis added), since nothing in the Act provides for such review. *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975); *Califano* v. *Sanders*, 430 U.S. 99, 110-111 (1977) (Stewart, J., concurring in the judgment).

The congressional intent to preclude review of Part B claims was reiterated in 1972 when 42 U.S.C. 1395ff was revised in certain respects. The Conference Report stated:

> Amendment No. 561: The Senate amendment added a new section to the House bill which would

> make clear that *there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B*, and that insofar as Part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.
>
> The House recedes.

H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972).[7] See also 118 Cong. Rec. 33992 (1972) (remarks of Sen. Bennett).

The Court of Claims' conclusion that it may review Prudential's determination of the amount of benefits payable on the thousands of individual Part B claims assigned to respondent is inconsistent with this congressional judgment. The court's holding threatens to intrude the Court of Claims into the carriers' day-to-day administration of the Medicare program and to open that court to the very flood of small claims Congress sought to foreclose. Compare *Johnson* v. *Robison*, 415 U.S. 361, 370-373 (1974). Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial

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[7] As orginally enacted in 1965, 42 U.S.C. 1395ff(b) provided that a beneficiary had a right to a hearing by the Secretary on Part A benefit determinations where the amount in controversy was $100 or more and to judicial review where the amount in controversy was $1,000 or more (42 U.S.C. (1970 ed.) 1395ff), but did not expressly bar the right to a hearing and judicial review where the amount in controversy was less than these amounts. As amended in 1972, 42 U.S.C. 1395ff(b)(2) now states that a hearing by the Secretary and judicial review are *not* available under that section where the amount in controversy is less than the prescribed amounts. The text of the 1972 amendments does not expressly refer to benefit determinations under Part B, but the Conference Committee report quoted in the text leaves no doubt that Congress intended to bar judicial review of such determinations in all cases.

determinations. See 42 C.F.R. 405.807 *et seq.* The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing in 7191 cases. If only a fraction of the total number of disappointed claimants were to seek review in the Court of Claims, the cited statistics indicate that there would be a considerable increase in that court's docket. This would, in turn, strain the scarce resources of the Secretary in defending against relatively minor monetary claims.[8]

2. The decision below also is contrary to the decisions of this Court in *United States* v. *Mitchell*, 445 U.S. 535 (1980), and *United States* v. *Testan*, 424 U.S. 392 (1976), regarding the jurisdiction of the Court of Claims under 28 U.S.C. (& Supp. III) 1491. In those cases, the Court held

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[8] The Court of Claims attempted to limit its holding by indicating that it would accept any case where it is alleged that a carrier "may have substantially violated * * * the provisions of the governing statute" (App. A, *infra*, 9a, quoting *Goldstein* v. *United States*, 201 Ct. Cl. 888, cert. denied, 414 U.S. 974 (1973)), but that it would not review benefit amount determinations in individual cases (*id.* at 14a). This attempt to confine the jurisdictional holding fails for a number of reasons. First, the standard virtually defies precise application, thereby inviting litigation, not preventing it, as the Court of Claims appeared to believe (*id.* at 14a-15a). Second, under the suggested standard, claims for increased Part B benefits would appear to be reviewable in any case in which a beneficiary (or his assignee) alleges that (1) the Medicare Act requires increased reimbursement; (2) a regulation is inconsistent with or unauthorized by the statute; or (3) the amount of benefits determined is less than would have resulted if the statute or regulation had been properly applied. Any artful pleader could bring his case under one of these tests, at least for purposes of defending against a motion to dismiss. Third, and most fundamentally, the Court of Claims failed to appreciate that every claim that a carrier's Part B benefit determination is inconsistent with the statute or implementing regulations is a challenge to the *amount* of benefits actually awarded and therefore foreclosed by 42 U.S.C. 405(h) and the text and legislative history of 42 U.S.C. 1395ff.

that 28 U.S.C. 1491 is only a jurisdictional statute that "does not create any substantive right enforceable against the United States for money damages" and that individual claimants therefore must look elsewhere for a waiver of sovereign immunity to suit with respect to their claims. 445 U.S. at 538; 424 U.S. at 398. See also *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976). To support respondent's statutory claims, then, it is necessary to find in the Medicare Act a substantive right to money damages for violations of the Act. The Court of Claims ignored that requirement in this case by concluding (App. A, *infra*, 6a-7a) that it had jurisdiction of respondent's statutory claims under 28 U.S.C. 1491 solely because respondent had alleged that Prudential's practices violated the Social Security Act.[9]

Moreover, the Court stressed in *Mitchell* and *Testan* that a waiver of sovereign immunity to suit in the particular statute relied upon " 'cannot be implied but must be unequivocally expressed' " (445 U.S. at 538; 424 U.S. at 399, both quoting *United States* v. *King*, 395 U.S. 1, 4 (1969)). There is no "unequivocally expressed" waiver of sovereign immunity to suit on individual claims to benefits under Part B of the Medicare Act. To the con-

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[9] Although the Court of Claims did not articulate its reasoning, the court may have believed that because the Medicare Act provides for the payment of benefits, it therefore " 'can fairly be interpreted as mandating compensation by the Federal Government' " (*United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport S.S. Corp.* v. *United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967)) whenever the statute is wrongly applied in the context of a particular benefit determination. See *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977). But the question under 28 U.S.C. 1491 is whether Congress has waived the United States' sovereign immunity to *suit* to recover the amounts owing as the result of an allegedly erroneous benefit determination, not whether it has waived an "immunity" to the payment of money. Thus, the mere fact that Congress has chosen to distribute monetary benefits administratively—or, here, through private insurance carriers—does not necessarily mean that Congress also intended to subject the United States to suits for damages for allegedly erroneous administrative decisions. Compare *Johnson* v. *Robison*, *supra*.

trary, the text and legislative history of the Medicare Act discussed above demonstrate that Congress deliberately withheld a right of judicial review of the amounts of benefits payable under Part B.

In addition, in the third sentence of Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), as incorporated into the Medicare Act, Congress has expressly foreclosed the federal district courts from exercising their Tucker Act jurisdiction (28 U.S.C. (& Supp. III) 1346(a)(2)) to entertain actions against the United States to recover on any claim arising under the Medicare Act. It is most unlikely that when Congress enacted the Medicare Act and expressly declined to waive the government's sovereign immunity to suit in district court for a money judgment under the Tucker Act, it nevertheless implicitly waived its immunity to suit under the Tucker Act in the Court of Claims. That result would be especially anomalous with respect to Part B Medicare claims, which typically involve relatively small amounts of money and therefore are precisely the type of cases for which Congress has provided Tucker Act jurisdiction in the district courts.[10]

Finally, the manner in which the Court of Claims will exercise its jurisdiction in these cases demonstrates the error of its jurisdictional holding. The court stated that it would not review the amount of individual benefit determinations (App. A, *infra*, 14a). Rather, if the court finds a statutory error, as it did in this case, it will remand to the carrier for an exercise of its discretion applying appropriate legal standards. Thus, the court

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[10] Indeed, where Congress provided for judicial review under the Medicare Act, it mandated that the procedures in 42 U.S.C. 405(g) be followed, including the requirement that a petition for review be filed within 60 days of the Secretary's decision. In contrast, a claimant would presumably have six years to bring an action in the Court of Claims under the Tucker Act. 28 U.S.C. (& Supp. III) 2415. Congress could not have intended such a result. *Califano* v. *Sanders*, *supra*, 430 U.S. at 108.

will not award a judgment of "actual, presently due money damages" (*United States* v. *King*, *supra*, 395, U.S. at 3), but will, instead, grant a form of equitable relief by way of remand. This underscores the conclusion that the Court of Claims is not the proper forum in which to resolve these claims. *United States* v. *Testan*, *supra*, 424 U.S. at 404-405; J. Rogers, *A Way Out of the Social Security Jurisdiction Tangle*, 21 Ariz. L. Rev. 689, 719-721 (1979)[11]

3. The decision of the Court of Claims is inconsistent with the decisions of other federal courts regarding the availability of judicial review of benefit determinations under the Medicare Act. In this case, the Court of Claims held that 42 U.S.C. 1395ff merely establishes procedures for review of certain determinations under the Act but does not bar other avenues of judicial review where 42 U.S.C. 1395ff is inapplicable (App. A, *infra*, 9a-11a). This conclusion was drawn directly from the court's earlier decision in *Whitecliff, Inc.* v. *United States*, *supra*,[12] in which it refused to apply the preclusion of

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[11] The Court need not consider whether jurisdiction lies in some forum to consider constitutional challenges to the Medicare Act or the manner of its implementation because the Court of Claims found respondent's constitutional arguments in this case to be insubstantial (App. A, *infra*, 22a). In any event, the Fifth Amendment Due Process Clause (including its equal protection component), upon which respondent relied below, does not mandate the award of money damages for violations, and cases arising under that Clause therefore do not fall within the Court of Claims' jurisdiction under 28 U.S.C. 1491. See *Muehlen* v. *United States*, 209 Ct. Cl. 690 (1976).

[12] In *Whitecliff*, the Court of Claims held that it had jurisdiction under 28 U.S.C. 1491 to review a challenge by a provider of services under Part A of the Act of the determination by a fiscal intermediary of the amount of reimbursements to which the provider was entitled for the years 1967 to 1970. Although the Court denied the government's petition for certiorari in *Whitecliff*, we had informed the Court (Petition for a Writ of Certiorari (No. 76-1188, Oct. Term 1976) at 6, 9-10) that disputes of this type arising after 1973 were expressly made subject to judicial review under 42 U.S.C. 1395*oo*. Hence, the Court may have concluded that the

review provisions of 42 U.S.C. 405(h) to Medicare cases despite the incorporation of that section in the Medicare Act. See 536 F.2d at 350-351.

The Court of Claims' reading of 42 U.S.C. 405(h) not to bar even non-constitutional challenges to benefit determinations not expressly made reviewable under the Medicare Act itself conflicts with the conclusion reached by a number of courts of appeals. *See Kechijian* v. *Califano*, 621 F.2d 1 (1st Cir. 1980); *Bussey* v. *Harris*, 611 F.2d 1001, 1005 n.5 (5th Cir. 1980); *Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979); *Trinity Memorial Hospital* v. *Associated Hospital Service, Inc.*, 570 F.2d 660, 666 (7th Cir. 1977); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 287-289 (8th Cir.), cert. denied, 429 U.S. 977 (1976).[13]

Several of these decisions make clear that there is no right of judicial review of a carrier's benefit determinations under Part B—the very determinations the Court of Claims found to be reviewable in this case. *Kechijian* v. *Califano, supra*, 621 F.2d at 3-4; *Bussey* v. *Harris, supra*, 611 F.2d at 1005 n.5; *Drennan* v. *Harris, supra*, 606 F.2d at 850 n.1; cf. *St. Louis University* v. *Blue Cross Hos-*

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question of jurisdiction over pre-1973 provider reimbursement disputes was not of sufficient continuing importance to warrant review. This same factor may explain the Court's denial of certiorari in *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328 (5th Cir.), cert. denied, 439 U.S. 893 (1978), which likewise involved a pre-1973 provider dispute under Part A.

The reviewability of carrier benefit determinations under Part B, in contrast, is of substantial continuing importance, because Congress has not provided an alternative means of judicial review of such determinations. Indeed, Congress reiterated its intention to *foreclose* judicial review of such determinations under Part B in the same 1972 amendments in which it granted a limited right of judicial review of provider disputes under Part A.

[13] However, some courts of appeals have taken the position that, notwithstanding 42 U.S.C. 405(h), they have jurisdiction under 28 U.S.C. 1331 of constitutional challenges to administration of the Medicare program. *Chelsea Community Hospital* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980); *St. Louis University* v. *Blue Cross Hospital Service, supra*, 537 F.2d at 291-293; see also *Kechijian* v. *Califano, supra*, 621 F.2d at 4.

pital Service, supra, 537 F.2d at 289, 293. Contrary to the Court of Claims, these courts have recognized that judicial review of Part B benefit determinations would "involve the court in the complex and detailed task of 'ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community' " and that " 'the proper amount of these charges is peculiarly suited to determination by a specialized agency' " (*Kechijian* v. *Califano, supra*, 621 F.2d at 3, quoting *St. Louis University* v. *Blue Cross Hospital Service, supra*, 537 F.2d at 289).

The holdings of these courts mean little, however, if claimants challenging benefit determinations under Part B may bring suit in the Court of Claims. Hence, review by this Court is essential to resolve the uncertainty in the lower courts on the important and recurring jurisdictional question presented in this case.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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MARCH 1981

APPENDIX A

UNITED STATES COURT OF CLAIMS

No. 374-77

ERIKA, INC.

v.

THE UNITED STATES

Oct. 22, 1980

Stephen H. Oleskey, Boston, Mass., attorney of record, for plaintiff. Timothy H. Gailey and Hale & Dorr, Boston, Mass., of counsel.

Dwight D. Meier, Washington, D.C., with whom was Asst. Atty. Gen. Alice Daniel, Washington, D.C., for defendant. Margaret Porter, Dept. of Health and Human Services, Washington, D.C., of counsel.

Before FRIEDMAN, Chief Judge, and DAVIS, NICHOLS, KASHIWA, KUNZIG, BENNETT, and SMITH, Judges, en banc.

ON CROSS-MOTIONS FOR PARTIAL SUMMARY JUDGMENT

FRIEDMAN, Chief Judge:

This case, before us on cross-motions for partial summary judgment,[1] presents two questions under

[1] At the time the motions were filed, defendant informed the court that the parties were involved in settlement negotiations over count I of the three-count supplementary petition. Neither party has addressed the issues in that portion of the complaint. This opinion, therefore, addresses only the issues under counts II and III.

part B of the Medicare program (Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1976)): (1) are any determinations relating to benefits under part B judicially reviewable, and (2) if the determinations here involved are reviewable, were the bases upon which they were made invalid because they are inconsistent with the statutory provisions governing those determinations? We answer both questions affirmatively. Accordingly, we grant the plaintiff's and deny the defendant's motions for partial summary judgment.

I.

A. The Medicare Program, which pays portions of certain medical expenses primarily for persons more than 65 years old, is divided into two parts. Part A is a hospital insurance program which covers all qualifying persons, and part B is a voluntary supplemental insurance program. Coverage under both parts of the program was extended on July 1, 1973, to any person, regardless of age, who requires kidney maintenance dialysis, and is otherwise covered by the Act. 42 U.S.C. § 426(e).

Part A of Medicare, *id.* §§ 1395c to 1395i-2, pays the costs of inpatient hospital services and extended care services. *Id.* §§ 1395c, 1395d. Patients receive the services without charge. Costs are paid out of the Federal Hospital Insurance Trust Fund, which is supported primarily by Social Security taxes. *Id.* § 1395i. Generally a hospital agrees to become a "provider of services" under the program and is reimbursed for its "reasonable costs" through a fiscal intermediary designated by the Secretary of Health,

Education, and Welfare. *Id.* §§ 1395f, 1395h.[2] If a provider is dissatisfied with the amount its intermediary awards, and if the amount in controversy is $10,000 or more, it may seek a hearing before the Provider Reimbursement Review Board. *Id.* § 1395*oo* (a). That Board's decision may be appealed to the Secretary. *Id.* § 1394*oo*(f).

Part B of Medicare, *id.* §§ 1395j-1395w, pays for the "reasonable charges" of physicians and various health services such as x-rays and laboratory tests. *Id.* §§ 1395*l*, 1395x(s). Individual participants pay premiums for coverage, which go into the Federal Supplementary Medical Insurance Trust Fund. *Id.* § 1395t. Part B benefits are administered by insurance carriers,[3] pursuant to contracts entered into with the Secretary. *Id.* § 1395u. The carriers set reasonable charges for 80 percent of which an individual, or a provider as assignee, may be reimbursed pursuant to guidelines set out in the Medicare statute and regulations. *Id.* The statute provides for "a fair hearing by the carrier" if a dispute arises over payment and the amount in controversy is $100 or more. *Id.* § 1395u(b)(3)(C). There is no provision for review of the carrier's decision by the Secretary or any governmental administrative agency.

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[2] In 1980 the name of the department was changed to Health and Human Services. Because the actions involved in this case predated that change, references are to the predecessor department.

[3] A carrier is an organization "lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier." 42 U.S.C. § 1395u(f)(1).

B. Plaintiff (Erika) is a major distributor of equipment and supplies used in kidney dialysis. It sells to hospitals, health care facilities, and patients items it produces and items manufactured by others. The Prudential Insurance Company of America (Prudential) was designated as plaintiff's carrier, and therefore was authorized to "make determinations of the rates and amounts of payments required . . . to be made to providers of services . . . [on] a reasonable charge basis" (*id.* § 1395u(a)(1)(A)). Under the statute Prudential was to determine "reasonable charges" that were to be no greater than:

> the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

Id. § 1395u(b)(3).[4]

Because Erika's sales represented almost all the sales of the relevant materials in the locality where its business was based, Prudential used Erika's

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[4] In 1977 Congress amended this section by changing "the fiscal year" to "the twelve-month period (beginning July 1 of each year)," due to a change in the federal fiscal year. 42 U.S.C. § 1395u(b)(3) (Supp. I 1977). Prior to 1976 the government's fiscal year ran from July 1 to June 30. Beginning in 1976, however, the government's fiscal year began on October 1. Despite the change in language, the effect of the provision remains the same. The time period from July 1 to June 30 is now called "the fee screen year." Since all the claims in this case arose prior to 1977, the earlier language is applicable here.

charges to set the reasonable charges for dialysis equipment and supplies. It treated Erika's charges as both the customary charges for a seller and the prevailing charges for the locality. Erika's prices were listed in the company's annual catalogues, effective July 1 of each year. The company also issued from time to time catalogue supplements that reflected changes in price. Beginning with the July 1974 issue, plaintiff sent to Prudential its yearly catalogue and supplements.

Prudential determined Erika's "reasonable charges" for its fiscal years (which began on July 1)—and hence the basis for its reimbursement—by reference to Erika's charges set forth in its annual catalogue effective July 1 of the preceding year. The reasonable charges for the fiscal year beginning July 1, 1975, therefore, were those listed in the July 1974 catalogue, and the reasonable charges for the year beginning July 1, 1976, were those listed in the July 1975 catalogue. Prudential did not change those "reasonable charges" to reflect Erika's price increases shown in the company's catalogue supplements. Prudential reimbursed Erika for 80 percent of the reasonable charges it thus determined. *Id.* § 1395/(a)(1).

In this suit Erika challenges Prudential's refusal to increase Erika's "reasonable charges" to reflect its price increases made during the intervals between the effective dates of its annual catalogues. Count II of the complaint concerns charges for heparin, an anticlotting drug used in dialysis, from July 1974 through May 1976. The heparin Erika sold was manufactured by other firms. Plaintiff states that a shortage of meat from which the drug is produced caused a severe shortage of heparin beginning in 1974, that manufacturers of the drug raised their

prices to Erika, and that Erika increased its prices for heparin five times during this period to reflect its increased costs in obtaining the drug. Although Erika sent Prudential its supplements showing the increased prices, Prudential reimbursed Erika on the basis of the July 1, 1974 prices until May 26, 1976. It then approved Erika's charges for heparin reflected in Erika's March 1, 1976 supplement as the reasonable charges for future sales.

Prudential, however, refused to increase its prior reimbursements to reflect Erika's four earlier price increases, on the ground it had no authority to make such retroactive adjustments. After a hearing, the hearing officer (a Prudential employee) upheld the determination.

Count III seeks reimbursement to reflect the difference between the higher prices Erika actually charged for other equipment and supplies sold to Medicare beneficiaries (based upon the increases set forth in the supplemental catalogues) and the July 1 prices upon which Prudential based its payments. Despite periodic requests from Erika, Prudential refused to make any changes in Erika's "reasonable charges" to reflect those interim price changes. After a hearing, the hearing officer denied Erika any additional payments.

II.

The plaintiff invokes our jurisdiction under the Tucker Act, 28 U.S.C. § 1491, which gives us jurisdiction over "any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department." [5] The plaintiff contends that the refusal of

[5] The plaintiff also asserts we have jurisdiction under section 10(b) of the Administrative Procedure Act, 5 U.S.C. § 703. In view of our holding that we have jurisdiction under

Prudential to determine its "reasonable costs" under part B of Medicare to reflect the interim increases in Erika's charges above those contained in its annual catalogues violated the fifth amendment to the Constitution and the provisions of the Social Security Act and the implementing regulations governing the determination of "reasonable costs." On its face, the petition states a claim within our jurisdiction under the Tucker Act.

The defendant contends, however, that under 40 U.S.C. § 1395ff Congress made benefit determinations under part B of Medicare not judicially reviewable. That section provides:

> (a) Entitlement to and amount of benefits
>
> The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) Appeal by individuals
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or section 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, or
>
> (C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

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the Tucker Act, we find it unnecessary to consider this additional basis of jurisdiction. *But cf. Califano* v. *Sanders*, 430 U.S. 99, 97 S. Ct. 980, 51 L.Ed.2d 192 (1977).

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Appeal by institutions or agencies

Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Section 405(g) of the Social Security Act permits any individual, after a final decision of the Secretary made after a hearing to which he was a party, to obtain review of the Secretary's decision by filing suit in the district court within 60 days. This provision would not permit Erika to obtain review of Prudential's denial of additional payment to it because that denial did not involve any "final decision" of the Secretary.

The government argues that under section 1395ff, the only issue upon which a hearing may be had before the Secretary under part B is whether an individual is entitled to benefits; and that there is no right to a hearing—and hence no right to judicial review—of a determination of the amount of benefits under part B, since the statute provides for a hearing on and judicial review of "amount" determinations only under part A. It contends that Erika's claim relates solely to the amount of benefits to which it is entitled and that section 1395ff therefore makes nonreviewable Prudential's refusal to pay Erika the additional amounts it seeks. The government argues further that the procedure provided in section 1395ff —a hearing before the Secretary and review in the district court—was intended to be the exclusive method for obtaining judicial review of Medicare determinations. In effect, the government argues that in section 1395ff Congress repealed by implication a portion of our jurisdiction under the Tucker Act.

We have rejected a similar contention by the government that section 1395ff and the provisions providing for district court review of determinations by the Secretary after a hearing bar us from reviewing decisions under part A of Medicare. In *Goldstein* v. *United States*, 201 Ct.Cl. 888, *cert. denied*, 414 U.S. 974, 94 S.Ct. 287, 38 L.Ed.2d 217 (1973), we held that with respect to the contention that a determination by a fiscal intermediary Provider Appeals Committee (1) "rested upon procedures which were constitutionally invalid or violative of the governing statute," or (2) "may have substantially violated the Due Process Clause of the Fifth Amendment or the provisions of the governing statute . . . the court has jurisdiction under 28 U.S.C. § 1491 and the finality

provisions of the medicare legislation do not bar judicial review." 201 Ct.Cl. at 889-90.

In *Whitecliff, Inc.* v. *United States*, 210 Ct.Cl. 53, 536 F.2d 347 (1976) *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977), we held that we had jurisdiction under the Tucker Act to review the contention that the decision of a Provider Appeals Committee denying a Medicare part A provider's claim to certain payments violated the Medicare statute. 210 Ct.Cl. at 58, 536 F.2d at 351. We stated that reading the Medicare provision there involved[6] to preclude judicial review would "prevent all review of very large categories of cases and issues, including constitutional questions, and . . . accord absolute finality to adjudications by private organizations . . . Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review." *Id.*, 536 F.2d at 350 (footnote omitted). We announced the following standard for judicial review of Medicare provider disputes:

> Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are appli-

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[6] The provision in question was § 405(h) of the Social Security Act, made applicable to Medicare through § 1395ii. It limited review of a determination by the Secretary under the Act to that provided in § 405(g). *Weinberger* v. *Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975). The government claimed in *Whitecliff* that § 405(h) also barred review of Medicare cases in this court. The court, however, refused to extend *Salfi* to such cases. 210 Ct.Cl. at 57-58, 536 F.2d at 350-51.

> cable, at least so far as to ensure compliance with statutory and constitutional provisions. In this court, 28 U.S.C. § 1491 (the Tucker Act) is the pertinent jurisdictional provisions both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers.

Id., 563 F.2d at 351 (footnote and citation omitted). Although *Goldstein* and *Whitecliff* involved the reviewability of benefit determinations under part A, their reasoning is no less applicable to benefit determinations under part B. Indeed, our rulings in those cases did not specifically focus upon either part A or part B, but, more broadly, were that we have jurisdiction under the Tucker Act to review Medicare determinations challenged as violating constitutional or statutory provisions. Here the plaintiff contends that there has not been "compliance with statutory and constitutional provisions" (*Whitecliff*, *supra*, 210 Ct.Cl. at 58, 536 F.2d at 350) by Prudential in determinating Erika's benefits. Our conclusion in *Whitecliff* that the mere lack of explicit provisions for judicial review does not bar consideration of those Medicare claims under the Tucker Act is equally sound when applied here.

The Supreme Court has recognized that even an explicit provision barring judicial review does not necessarily do so in all cases. Section 211(a) of title 38 makes decisions of the Veterans' Administrator "final and conclusive" and provides that "no . . . court of the United States shall have power or jurisdiction to review any such decision by an action in the nature of mandamus or otherwise." Despite this sweeping language, the Supreme Court held in

Johnson v. *Robinson*, 415 U.S. 361, 94 S.Ct. 1160, 39 L.Ed.2d 389 (1974), that the federal courts could entertain a constitutional challenge to the Administrator's refusal to provide veterans' educational benefits to a conscientious objector who performed civilian service in lieu of military service. Noting that section 211(a) did not explicitly bar judicial consideration of Robinson's constitutional claims (*id.* at 367, 94 S.Ct. at 1165), the Court concluded that "neither the text nor the scant legislative history of § 211(a) provides the 'clear and convincing' evidence of congressional intent required by this Court before a statute will be construed to restrict access to judicial review. *See Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141, 87 S.Ct. 1507, 1511, 18 L.Ed.2d 681 (1967)." *Id.* 415 U.S. at 373-74, 94 S.Ct. at 1168-1169.

Similarly, we have recognized that although the Civil Service Retirement Act provided that the decisions of the Civil Service Commission on questions of disability and dependency "are final and conclusive and are not subject to review," a court might set aside a Commission determination "where there has been a substantial departure from important procedural rights, a misconstruction of the governing legislation, or some like error 'going to the heart of the administrative determination.'" *Scroggins* v. *United States*, 184 Ct. Cl. 530, 533-34, 397 F.2d 295, 297, *cert. denied*, 393 U.S. 952, 89 S.Ct. 376, 21 L.Ed.2d 363 (1968), quoting *Gaines* v. *United States*, 158 Ct.Cl. 497, 502, *cert. denied*, 371 U.S. 936, 83 S.Ct. 309, 9 L.Ed.2d 271 (1962). *See also Polos* v. *United States*, Ct.Cl., 621 F.2d 385 at 391 n.9 (1980).

If, as those cases hold, the courts may entertain constitutional and statutory challenges to administrative action even where the governing statute explic-

itly bars judicial review, *a fortiori* the courts may do so where, as here, the alleged bar to judicial review is merely implicit in the statutory language and structure.

The government contends, however, that the legislative history of section 1395ff evidences a clear congressional intent to bar judicial review of any benefit determinations under part B of Medicare. It refers to the following statement in the Senate Committee Report on the Medicare bill:

> Under the supplementary plan [part B], carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.

S.Rep.No.404, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S.Code Cong. & Ad. News, pp. 1943, 1995. The governing also cites the following statement by Senator Bennett made during Senate debate on a 1972 amendment that changed the language of section 1395ff(b):

> The situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters. The law refers to "entitlement" as being an issue subject to court review and the word was intended to mean eligibility to any benefits of medicare but not to decisions on a claim for payment for a given service.

118 Cong.Rec. 33,992 (1972).

These statements do not constitute "clear and convincing" evidence (*Johnson, supra*, 415 U.S. at 373, 94 S.Ct. at 1168) the Congress intended to bar judicial review of constitutional and statutory challenges to benefit determinations under part B of Medicare. The fair import of these statements is that Congress intended to bar judicial review of the amount of a particular benefit determination—as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services. Indeed, this court implicitly so ruled in *Goldstein, supra*, when it stated that "it is precluded by 42 U.S.C. § 1295ff and § 405(h) from reviewing or overturning the determination of the Provider Appeals Committee *except* insofar as such determination" rests upon constitutional or statutory error. 201 Ct.Cl. at 889 (emphasis supplied).

What this legislative history indicates is that Congress wanted to avoid flooding the courts with a large number of small claims in which beneficiaries challenged the amount of reimbursement allowed for a particular service or product. *Cf. Johnson, supra*, 415 U.S. at 370-72, 94 St.Ct. at 1167-1168. That this was the primary purpose of Congress in the provision is confirmed by the fact that under part A of Medicare Congress barred judicial review of the Secretary's determination if the amount in controversy is less than $1,000.

The congressional objective to prevent the courts from being burdened with a large number of small individual claims seeking greater reimbursement would not be thwarted by permitting judicial review of contentions that particular benefit determinations violated constitutional or statutory provisions. For once a particular contention of that kind had been

adjudicated, that issue would be settled, and there would be no occasion for further litigation of the point. *Cf. Johnson, supra*, 415 U.S. at 373, 94 S.Ct. at 1168.

III.

A. In one significant respect the basis upon which Prudential determined Erika's "reasonable charges" did not comply with the Medicare statute and the implementing regulations.

As noted in section I.A. above, the statute provides that a reasonable charge (referred to as the "prevailing charge" in the statute) cannot exceed 75 percent of the customary charge for similar services in the locality "during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made." 42 U.S.C. § 1395u(b)(3). The Secretary's regulations similarly provide for a maximum reasonable (prevailing) charge of not more than 75 percent of the customary charge "during the calendar year preceding the start of the fiscal year in which the claim is submitted or the request for payment is made." 20 C.F.R. § 405.504(a)(2)(i) (1976).[7] The touchstone for determining reasonable charges under both the statute and the regulations is the customary charge "during the calendar year" preceding the fiscal year for which reimbursement is sought.

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[7] References to the regulation are to the 1976 Code of Federal Regulations unless otherwise indicated. In 1977 the entire chapter involved here was moved to become chapter IV of title 42 concerning Public Health, without major changes. Subsequent to 1976, however, when the federal fiscal year was changed, the regulation, like the statute, was altered. 42 F.R.D. § 405.504(a)(2)(i) (1979). *See* note 4, *supra*.

In the present case Prudential treated Erika's charges as the customary charges (and the prevailing charges) for the service in the locality. Prudential, however, did not base its determination of Erika's "reasonable charges" upon Erika's customary charges "during" the preceding calendar year. Instead, it looked only to Erika's charges on July 1, the first day of Erika's fiscal year. In so doing, Prudential ignored the statutory directive, repeated in the regulation, that it was to make its determination of Erika's charges for the current fiscal year on the basis of those charges during the preceding calendar year. The statute and regulations did not permit Prudential to consider only Erika's charges on a single day in the middle of the preceding calendar year.

If Erika's charges had remained the same during the entire preceding calendar year, Prudential's error would have been immaterial. Erika, however, increased its charges during the preceding calendar year. Prudential's method of determining Erika's "reasonable charges" did not reflect those increases.

Prudential's failure to comply with the statutory directive is shown by the carrier's determination of Erika's "reasonable charges" for the drug heparin. For the fiscal year beginning July 1, 1975 (except for the 35 days after March 26, 1976, when Prudential based its reimbursement of Erika's charges on the latter date), Prudential reimbursed Erika on the basis of Erika's July 1, 1974 charges. In September 1974, Erika increased its charges for heparin, but the "reasonable charges" Prudential allowed did not reflect that increase.

The statutory standard that Erika's "reasonable charges" be calculated on the basis of Erika's charges during the preceding calendar year required Pruden-

tial's determination to reflect all price changes the provider made during that entire year. With respect to Erika's "reasonable charges" for heparin for the fiscal year 1975-76, this meant that Prudential's determination had to reflect the September 1974 price increase. Conversely, if during the first 6 months of 1974 Erika's charge for heparin was lower than its charge on July 1 of that year, Prudential should have taken that fact into account.

On the present record, we cannot determine what Erika's customary charges were for its drugs and services for each of the calendar years involved. Nor do we attempt to prescribe the method by which the carrier should make that determination. Prudential might decide to average the different charges made during the calendar year, or to allocate the different charges on the basis of the time each was in effect, or to determine the mean charge, or to use some combination of these methods. Perhaps Prudential can devise a better method of calculation.

The selection of the appropriate method of calculation is for Prudential to determine in the first instance. The carrier has considerable discretion to adopt whatever method of calculation it concludes would most accurately measure and reflect Erika's customary charges during the preceding calendar year. Our point simply is that under the statute and regulations, Prudential cannot ignore the changes in Erika's prices during the preceding calendar year and base its determination solely upon Erika's catalogue prices as of July 1.

In determining Erika's reasonable charges and reimbursing the provider for 80 percent of that amount, Prudential is acting for the Secretary pursuant to delegated statutory authority and the Sec-

retary's regulation. Prudential is an "administrative or executive body" under 28 U.S.C. § 1491, to which we may "remand appropriate matters . . . with such direction as [we] may deem proper and just." *Cf. Weinreb* v. *United Medical Service, Inc.*, 392 F.Supp. 45, 46 (S.D.N.Y. 1975); *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F.Supp. 532, 534-35 (C.D. Cal. 1968). We therefore shall remand the case to Prudential to redetermine Erika's reasonable charges in accordance with this opinion.

B. Erika contends, however, that its "reasonable charges" for which the statute provides reimbursement are the amounts actually billed to its customers rather than its charges during the preceding year, and that Prudential therefore was required to increase the amount of reimbursement whenever Erika itself increased its prices. As we have explained in section III.A., however, Congress has provided that the reasonable charge cannot exceed the prevailing charge of 75 percent of the customary charges during the preceding calendar year.

Erika also states that because all of its sales were made through its headquarters in New Jersey and its Medicare claims were processed by Prudential (the carrier serving New Jersey) rather than by carriers throughout the country where Erika's patients were located, Erika's customary charges became the prevailing charges in the locality, which Prudential then used to determine Erika's reasonable charges. Erika contends that if its patients had asserted their own claims for reimbursement, rather than assigning the claims to Erika, they would have received higher reimbursement from other carriers throughout the country than Erika received from Prudential.

Of course, there is no way of knowing the amounts other carriers would have allowed if Erika's patients rather than Erika had presented the claims for reimbursement. Erika's contention that the amounts of reimbursement the other carriers would have allowed would have been higher than Prudential's payments thus is wholly speculative.

An equally serious flaw in Erika's argument is that its predicament, if such it be, is of its own choosing. Erika, for reasons of its business convenience and advantage, decided to accept assignments of its patients' Medicare claims rather than to collect directly from the patients and let the latter seek reimbursement from Medicare carriers in their locality. Having made that election, Erika cannot now legitimately complain because Prudential treated the claims Erika presented as claims by Erika rather than claims by Erika's patients. Although Erika's right to assert those claims derived from the assignment of the claims by the patients, it was not unreasonable for Prudential to deal with the claims presented by Erika as Erika's claims.

C. With respect to the drug heparin, which Erika did not manufacture but merely resold, Erika increased its prices five times between the promulgation of its July 1, 1974 price catalogue and May 26, 1976. It made these price increases allegedly solely because of price increases imposed by Erika's suppliers. On the latter date Prudential ruled that it would use Erika's then current higher price as a basis for future payments. Prudential, however, declined to give Erika any retroactive adjustment to reflect its past higher prices. It refused to make that retroactive adjustment either solely or primarily because of Intermediary letter 72-13, in which the Department of

Health, Education, and Welfare instructed carriers that adjustments in reimbursement payments on equitable grounds "may apply prospectively only." Erika contends that Prudential's reliance upon this letter was improper, and we agree.

As Prudential points out, Intermediary Letter 72-13 was issued in May 1972. It was designed to explain and to aid carriers in applying a Price Commission ruling concerning base prices for Medicare services during Phase II of the Wage and Price Control Program. It was in explaining the circumstances in which upward price adjustments could be made for equitable considerations that the letter stated that those adjustments "may apply prospectively only."

In terms, the letter applied only to adjustments for the fiscal year 1973. Moreover, as the hearing officer noted, Intermediary Letter 72-13 subsequently was declared to be "obsolete." The hearing officer concluded, however, that this latter action "does not necessarily negate its historical precedent." For this latter conclusion, the hearing officer relied upon two letters written by officials of the Department of Health, Education, and Welfare expressing their opinion that retroactive equity adjustments could not be made.

Prudential's reliance upon this letter, which did not cover the years in dispute here and which were declared "obsolete," was misplaced. Similarly, the two statements of the HEW officials which the hearing officer found convincing cannot be deemed to reflect the considered judgment of the Secretary. We therefore conclude that since Prudential's denial of a retroactive equitable adjustment rested either completely or primarily upon this Intermediary Letter, it cannot stand. Accordingly, we vacate that determination and remand this aspect of the case to Prudential

to reconsider its refusal to award retroactive benefits without reliance upon the Intermediary Letter or the two other opinions.

In so doing, we indicate no views on whether a retroactive adjustment should be made. That is a matter for Prudential to determine, in light of whatever governing standards and policies the Secretary has promulgated for retroactive adjustments.

D. In a period of rapidly rising costs and prices, such as the present, a provision requiring reimbursement upon the basis of charges during the prior calendar year may result in unfairness. It is Congress, however, which provided that standard for reimbursement under Medicare. If any change is to be made in that standard, it must come from Congress, not from this court.

The regulations give carriers substantial flexibility in setting reimbursement rates to look at more than just the customary and prevailing charges. In determining reasonable charges a carrier also may consider "[o]ther factors that may be found necessary and appropriate with respect to a specific item or service to use in judging whether the charge is inherently reasonable." 20 C.F.R. § 405.502(a)(4). Prudential apparently did consider Erika's special circumstances in connection with heparin when in May 1976 it granted Erika an increase that allowed the provider to be reimbursed at its current charges instead of its charges for the preceding calendar year. The determination whether to grant particular adjustments and permit departures from prevailing charges during the preceding calendar year, however, is within the discretion of the carrier. We cannot direct Prudential whether or how to exercise that discretion in a particular case.

E. Finally, Erika contends that Prudential's refusal to reimburse it on the basis of its current charges denied it due process and equal protection in violation of the fifth amendment to the Constitution. These constitutional claims are insubstantial. It was reasonable for Congress, in order to control Medicare costs and to provide an orderly system for administering this vast and complex program, to base reimbursement upon charges made during the prior year. Erika's participation in the Medicare program was voluntary. The limitations upon reimbursement that Erika here challenges did not deny Erika due process or equal protection. *See, e.g., Califano* v. *Aznavorian*, 439 U.S. 170, 99 S.Ct. 471, 58 L.Ed.2d 435 (1978); *Mathews* v. *Eldridge*, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976); *Dandridge* v. *Williams*, 397 U.S. 471, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1970).

CONCLUSION

Plaintiff's motion for partial summary judgment is granted, and defendant's motion for partial summary judgment is denied. The case is remanded to the Prudential Insurance Company of America for further proceedings in accordance with this opinion.

NICHOLS, Judge, concurring:

I agree in the result and in the court's able opinion except as specified. I write separately on jurisdiction because I continue to believe that a practical necessity exists to advert to the doctrine of strict construction of the consent to be sued whenever we allow a claim that is in any way a departure from our usual routine. Since this is our first claim by a Medicare Part B provider, the instant case is novel in

that sense. Defendant is likely to abandon here any but *pro forma* insistence on jurisdictional objections when we have once established a precedent in favor of our own jurisdiction. Defendant before us does not waste time arguing issues we already have decided. Strict construction being jurisdictional, however, defendant always can invoke it in petitioning for certiorari without having said much or anything to alert us. We should, therefore, routinely show we have considered jurisdiction and have an answer, if we do, to all possible jurisdictional problems, whether or not urged before us by defendant.

When one considers the amazing changes that have occurred over a century of time in the meaning of the Constitution and laws, generally, as construed by the U.S. Supreme Court, the infrequency of its deviations from strict construction of the consent to be sued is almost anomalous. The doctrine is relatively firm when all else is in flux. It was already old when applied to the newly passed Tucker Act in *United States* v. *Jones*, 131 U.S. 1, 9 S.Ct. 669, 33 L.Ed. 90 (1889), and we have just now seen a litigant whose cause we favored stranded on it just as was claimant Jones. *United States* v. *Mitchell*, 445 U.S. 535, 100 S.Ct. 1349, 63 L.Ed.2d 607 (1980). It is true that Mr. Justice Holmes' colleagues allowed him to say for them, referring to the Tucker Act, in *United States* v. *Emery*, 237 U.S. 28, 32, 35 S.Ct. 499, 500, 59 L.Ed. 825 (1915):

> * * * [It is an] inadmissible premise that the great act of justice embodied in the jurisdiction of the Court of Claims is to be construed strictly and read with an adverse eye. * * * [Cases omitted].

Though the result of that case has stood, the language does not fairly and fully represent the policy of the Supreme Court then or now. Holmes himself in *United States* v. *Milliken Imprinting Co.*, 202 U.S. 168, 26 S.Ct. 572, 50 L.Ed. 980 (1906), thought he was being liberal to allow us to reform a contract and enforce it as reformed, though the Act then specifically granted equity jurisdiction. *Annell* v. *United States*, 384 U.S. 158, 86 S.Ct. 1384, 16 L.Ed.2d 445 (1966), is the only holding in conflict with the preponderance of cases. The quote proves only that nobody dared to edit Holmes' dicta. It, and the Lincoln quote that decorates our lobby, should never be reproduced without a qualifying reference to the doctrine of strict construction of the consent to be sued, and a tolling of the bell for all the litigants who have relied on such rhetoric in vain.

Among its other manifestations, the doctrine overturns the usual rule that repeals by implication are not favored. Partial repeals of the Tucker Act by implication are favored. Indeed, we ourselves recognized that such a partial repeal by implication did occur when we took jurisdiction of some Medicare Part A claims, but were careful to spell out, only those for which no district court remedy was provided, as the present opinion of this court correctly states in discussing *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347 (1976), *cert. denied*, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977). It is scarcely necessary to point out that in the absence of other provisions, all Medicare provider claims could have been sued on under 28 U.S.C. § 1491 (Tucker Act) nor that the provisions which reduced the number to less than all made no express reference to the Tucker Act and must, therefore, have

effected the partial repeal that did effect by implication only. And by inadvertence too, quite likely.

Congress is aware how easily it can effect a partial repeal of the Tucker Act by implication, and when it adverts to the problem and does not desire such partial repeal, it is careful to say so. A conspicuous long standing example is 28 U.S.C. § 1346(a). A more recent one is Pub.L.No. 92-562, Act of October 25, 1972, 86 Stat. 1176, codified 28 U.S.C. § 2409a. In *Fiorentino* v. *United States*, 221 Ct.Cl. ——, 607 F.2d 963 (1979), *cert. denied*, 444 U.S. 1083, 100 S.Ct. 1039, 62 L.Ed.2d 768 (1980) we discuss the effect of a partial implied repeal of the Tucker Act, there involved point out its involvement in *Brown* v. *GSA*, 425 U.S. 820, 96 S.Ct. 1961, 48 L.Ed.2d 402 (1976), and show that sovereign immunity (and the need of an express consent to be sued) greatly strengthens the probability that a partial repeal of the Tucker Act by implication has been effected in any class of case if the question arises.

There is, however, a big difference between an implied partial repeal of the Tucker Act in course of providing a seemingly adequate remedy elsewhere than in this court (actuated, perhaps, by a commendable desire to guarantee us an easy life with long vacations) and such an implied partial repeal in course of expressly denying relief elsewhere. Much will depend on the facts, but I do not think the Supreme Court has yet said or done anything to disable us from requiring defendant to show us express repeal of the Tucker Act in such circumstances. That is the effect of what we do here today. I deem it possible the momentum the Supreme Court has acquired on the strict construction issue may carry it to the length defendant's argument here would re-

quire, but I think we should let them get there first. It never does for a lower court to anticipate Supreme Court decisions. If anyone is to make such a flagrant and utter repudiation of the Holmes' *Emery* case rhetoric, it should be the Supreme Court, not ourselves. We can at least enjoy deeming ourselves to be in this area "the nation's conscience" until we are reversed, and the true straitness of the consent to be sued pointed out to us once again.

The difference is one that will appeal to most minds, but it is important not to overstress it. In our reasoning on consent to be sued issues, it is an error to be governed by the thought that the claimant must have a remedy here because he has none elsewhere. Our now reversed decision in *Mitchell* was infected by this fallacy. As I there pointed out, concurring, Congress has historically withheld its consent to be sued on many classes of claims over long periods, intentionally, preferring to handle itself the importunities of the claimants. The most that can be made of our *Mitchell* reasoning is that in some instances it will be a useful guide to legislative intent if otherwise unascertainable. It is helpful to ask sometimes whether a contemplated result is one the Congress would have wanted, if it had adverted to the problem. This reasoning cannot be used to clarify a consent to be sued, not stated in express terms, but perhaps it can if consent was once expressly granted and it is a later withdrawal of consent that is sought by defendant to be implied. In the instant case it is difficult to believe Congress would have wished to leave Erika, Inc. without a judicial remedy against the virtual spoliation revealed by the instand record, when such a remedy would have been unquestionable if Congress had just said nothing in its Social Security legislation about appeals and judicial review.

If a claimant can found a "colorable" claim on the Constitution, this may have an effect on the durability of an express consent to be sued against an implied withdrawal of it. *See Califano* v. *Sanders*, 430 U.S. 99, 109, 97 S.Ct. 980, 986, 51 L.Ed.2d 192 (1977). Acts of Congress relating to court jurisdiction and consent to be sued are to be construed in harmony with and not to thwart the purposes of the Constitution. *Russian Volunteer Fleet* v. *United States*, 282 U.S. 481, 491, 51 S.Ct. 229, 232, 75 L.Ed. 473 (1931). *Cf. Atkins* v. *United States*, 214 Ct.Cl. 186, 556 F.2d 1028 (1977), *cert. denied*, 434 U.S. 1009, 98 S.Ct. 718, 54 L.Ed.2d 751 (1978) (concurring opinion). I would consider Erika's constitutional claims to be "colorable," not "insubstantial" or "frivolous," but it is not necessary to decide if they are valid. A claim to a construction of a statute or regulation, strongly influenced by constitutional considerations, also must fall in the category of colorable constitutional claims. At any rate, in my view, defendant quite possibly was attempting to defend an unconstitutional result on jurisdictional grounds.

We have learned not to characterize a fifth amendment taking by what the taker chooses to call it. If the United States interposes between a manufacturer or dealer and his customers, leaving him no alternative but to sell his product to the government on the government's terms, that is a taking. The contrary argument or defense here is that Erika, Inc. could refuse to do any business with the United States, sell its kidney dialysis material to patients for cash only, and leave the patients to collect the government benefits when entitled. Whether this is valid depends on economic factors we would need evidence to resolve that we do not have. A trial to obtain it is not nec-

essary in the absence of indications that recovery on a fifth amendment theory would produce a larger award that what will ensure on the theory we espouse. Still, the constitutional theory is colorable, and being colorable, it aids our jurisdiction, which otherwise is probable but far from certain. The court therefore ought not to have given the theory the short shrift it has, and it should not have said Erika's participation in the program was "voluntary," which may be true and may be but a legal fiction. The voluntary nature of anyone's transactions with the government is not a simple matter to determine. Cf. *Sandnes' Sons, Inc.* v. *United States*, 199 Ct.Cl. 107, 462 F.2d 1388 (1972) where voluntariness was debated between majority and minority of this court sitting en banc. Erika may have, probably has, made its constitutional allegations mostly to aid our jurisdiction, and we should not spurn this aid.

APPENDIX B

IN THE UNITED STATES COURT OF CLAIMS

No. 374-77

ERIKA, INC.

v.

THE UNITED STATES

Filed Oct. 24, 1980

ORDER

This case comes before the court *sua sponte*, and on the basis of the remand as directed in the court's opinion of October 22, 1980.

IT IS FURTHER ORDERED that the case is removed from the court's docket and is no longer a pending case before this court.

BY THE COURT

/s/ Daniel M. Friedman
DANIEL M. FRIEDMAN
Chief Judge

Oct. 24, 1980

APPENDIX C

IN THE UNITED STATES COURT OF CLAIMS

No. 374-77

ERIKA, INC.

v.

THE UNITED STATES

Stephen H. Oleskey, attorney of record for plaintiff. *Timothy H. Gailey* and *Hale and Dorr*, of counsel.

Dwight D. Meier, with whom was *Assistant Attorney General Alice Daniel*, for defendant. *Margaret Porter*, Department of Health and Human Services, of counsel.

Before FRIEDMAN, *Chief Judge*, DAVIS, NICHOLS, KASHIWA, KUNZIG, BENNETT, and SMITH, *Judges, en banc.*

ON DEFENDANT'S MOTION FOR REHEARING

ORDER

The defendant has requested us to make clear that our opinion of October 22, 1980, was not intended to

invalidate a portion of section 5010.1 of the Medicare Carriers Manual.

In that opinion we held that in determining the plaintiff's reimbursable "reasonable charges" for Medicare services, The Prudential Insurance Company of America (Prudential), the plaintiff's insurance carrier, did not comply with the Medicare statute and the implementing regulations of the Secretary of Health, Education, and Welfare. The statute and regulations require that Medicare reimbursement be based upon the customary charge for such services in the locality where rendered during the "calendar year" "preceding" the year for which reimbursement was sought. Prudential based its determination of the plaintiff's reimbursement upon the plaintiff's charges on July 1, and refused to take account of the changes the plaintiff made in those charges, either before or after that date. We held that this was error because "[t]he statute and regulations did not permit Prudential to consider only Erik's charges on a single day in the middle of the preceding calendar year." Slip. op., p. 11.

Section 5010.1 of the Manual provides:

> When a carrier does not have adequate statistics on charges for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June 30 of that calendar year only should be used. The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during the calendar year.

In our decision we were not purporting to, and did not, determine the validity of that provision. All

we held was that "under the statute and regulations, Prudential cannot ignore the changes in Erika's prices during the preceding calendar year and base its determination solely upon Erika's catalogue prices as of July 1." Slip op., pp. 12-13.

More than a month-and-a-half after the government filed its motion for rehearing, the plaintiff filed a memorandum in opposition. In that memorandum the plaintiff stated that at a recent conference with defendant's counsel and representatives of the Social Security Administration and Prudential, the plaintiff's counsel was informed that because of the passage of time, Prudential no longer had the necessary data (which the plaintiff previously had supplied) to make the calculations required under our decision of October 22, 1980. The plaintiff states that it was informed that if the court grants the government's motion for rehearing, Prudential will assert

> that under the quoted language of section 5010.1 of the Medicare Carriers Manual it should be allowed on remand to use the single date catalogue approach which it was sued for using in the first place. It seeks, therefore, to evade completely the decision of this Court since such an action would result in Erika receiving no relief whatsoever for the improper actions of Prudential.

The clarification of our opinion that we are making in response to the defendant's motion for rehearing is intended solely to make clear that our decision implies nothing with respect to the validity or invalidity of the provision of section 5010.1 of the Manual quoted above. Prudential is required to carry out our mandate that on remand it conduct "further pro-

ceedings in accordance with this opinion." Prudential cannot now invoke section 5010.1 in an attempt to avoid compliance with our decision, on the basis of its claim that it no longer has the data that the plaintiff submitted to it.

BY THE COURT

/s/ Daniel M. Friedman
DANIEL M. FRIEDMAN
Chief Judge

Feb. 6, 1981

APPENDIX D

FORMAL HEARING PURSUANT TO TITLE XVIII, PART B, OF THE SOCIAL SECURITY ACT—("MEDICARE")

IN THE MATTER OF: ERIKA, INC., 560 Sylvan Avenue, Englewood Cliffs, NJ 07632, CLAIMANT

and

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, CARRIER

DETERMINATION OF HEARING OFFICER

Hearing held on February 11, 1977, at The Prudential Plaza Building in Newark, New Jersey.

Hearing Officer:

Henry A. Hartley

Appearances:

For the Claimant:

David T. Smith
Director—ERIKA, Inc.

Joseph E. Carson, Esquire
Attorney for ERIKA, Inc.

For the Carrier:

Robert W. Giordano
Associate Manager
Medical Administration Division

MATTER AT ISSUE:

Concerns the Claimant's request for retroactive equity increases for Heparin and CDAK #4 Hollow Fibre Kidney, which was denied by the Carrier. The Claimant has estimated the amount(s) at issue to be "in excess of $200,000 for both items".

HEARING TESTIMONY:

It was initially and mutually agreed by all parties present at the Hearing that the identical principle(s) and/or reasoning for the Carrier's denial of the Claimant's request for retroactive equity increases for Heparin and CDAK #4 Hollow Fibre Kidney was reasonably equally applicable. Although the separate files and/or exhibits for each item were individually reviewed and discussed, the testimony was primarily directed to the fact that the applicable Law, Regulations and Guidelines applied to both items.

Claimant succinctly described the CDAK #4 Hollow Fibre Kidney as a "catalog designation for a coil device . . . in the artificial kidney machine. It is a deletable part of the machine that is used and must be replaced on a regular basis". Heparin was described as "an anti-clotting agent . . . used for each dialysis treatment".

It was established that the Claimant discovered a printing error in their 1974 catalog for CDAK #4 and contacted the Carrier in February 1976, requesting an equity adjustment back to July, 1974. The price was listed at $246 whereas, the correct price was $294. The Carrier immediately agreed to the increased adjustment, but emphasized it could be on a prospective basis only. Approximately six months later, the Carrier received numerous forms from the Claimant, requesting recalculation of the previous al-

lowances. Claimant was again advised that equity increases or adjustments could be prospectively only. On May 18, 1976, the Claimant contacted the Carrier and advised that pursuant to the shortage of beef in November, 1974 . . . "and continuing to date" . . . resulting in the unavailability of raw materials needed to manufacture Heparin . . . "prompting absolutely astronomical increases in the market supply prices" . . . and requested and adjustment in the charge screen retroactively. The Carrier again advised the Claimant they could only grant an equity increase and/or adjustment prospectively.

Since the Carrier's decision to deny retroactive equity increases and/or adjustments were primarily premised on a provision in the Intermediary Letter 72-13 which provides: "Such adjustments may apply prospectively only"; the Claimant primarily challenged the Carrier's reasoning as follows:

(1) IL 72-13 was issued for explaining Phase II of the Economic Stabilization Program and applied exclusively to the fiscal year 1973. The phrase "prospective only" appears nowhere else in the manual, regulations or guidelines. Of significant importance, IL 72-13 has been "obsoleted" since the publication of Intermediary Letter Listing of July, 1974.

(2) IL 72-13 makes provision for retroactive correction—at least for CDAK #4. Part F, correctness of errors in charge screens, provides that errors in establishment or application of charge screens due to inaccurate data or other mistakes may be corrected during period of stabilization. Also, there is no similar prohibition on retroactive adjustment.

(3) The decision to deny retroactively is inconsistent with the established practice under the End-Stage Renal Program. The Bureau of Health Insurance

had allegedly made retroactive adjustments of estimated customary charges for kidney dialysis in circumstances not significantly different from the issues involved in this Hearing. Reference was made to a calculated adjustment made by BHI in 1975 in favor of the Queens (NY) Artificial Kidney Center.

APPLICABLE LAW, REGULATIONS, AND GUIDELINES:

On examination of specific parts of TITLE XVIII, Health Insurance for the Aged, and Public Law 89-97 of the Social Security Act, as amended, I find that the following sections of the Act, are relevant to this case:

> "*Section 1832 (a).* The benefits provided to an individual by the insurance program . . . shall consist of (1) entitlement to have payment made to him or on his behalf . . . for medical and other health services . . . ."
>
> "*Section 1833 (a).* . . . there shall be paid from the Federal Supplementary Medical Insurance Trust Fund . . . amounts equal to—(1) . . . 80 percent of the reasonable charges for the services . . . ."
>
> "*Section 1842 (a).* In order to provide for the administration of the benefits under this part, . . . the Secretary is authorized to enter into contracts with Carriers . . . which will . . . (1) (A) make determinations of the rates and amounts of payment required pursuant to this part to be made to providers of services . . . on a . . . reasonable charge basis. . . . (3) Each such contract shall provide that the Carrier . . . (B) will take such action as may be necessary

to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable. . . . (E) . . . there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services."

"*Section 1871.* The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. . . ."

The following Regulations of the Secretary of Health, Education and Welfare, promulgated for the administration of supplementary medical insurance program are applicable to this case:

"*405.502 Criteria for Determining Reasonable Charges—*

(a) Criteria—The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other persons as well as others in the locality. The two criteria set out in this law which are considered in determining reasonable charges are:

(1) The customary charges for similar services generally made by the physician . . .; and

(2) The prevailing charges in the locality for similar services.

* * * * *

(c) Application of Criteria—In applying these criteria, the Carriers are to exercise judgement [sic] based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable . . . ."

"*405.503 Determining Customary Charges.*—The term 'customary charge' will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. . . .

* * * * *

(d) *Revision of customary charge.* . . . Where on the basis of adequate evidence, the Carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered *thereafter* to supplementary insurance beneficiaries. . ."

"*405.504 Determining Prevailing Charges.*—(a) Range of charges.—The term 'prevailing charges' refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. . . . Prevailing charges are derived from the overall pattern existing within a locality. . . . With respect to claims received by Carriers on or after January 1, 1971, no charge may be determined to be reasonable if

it exceeds the higher of (1) the prevailing charge limit that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 per cent of the customary charges made for similar services in the same locality during the calendar year preceding the start of the fiscal year in which the determination is made, or (2) the prevailing charge limit in effect on December 31, 1970, provided such prevailing charge limit had been found acceptable by the Secretary."

"*405.860 Authority of the Hearing Officer*—The Hearing Officer in exercising the authority to conduct a Hearing under Section 1842 (b) (3) (C) of the Act is to comply with all the provisions of the Title XVIII of the Act and regulations issued thereunder, as well as policy statements, instructions and other guides issued by the Social Security Administration in accordance with the Secretary's agreement with the Carriers."

The following excerpts from DHEW Social Security Administration Intermediary Letters are applicable to this case:

"*Part B Intermediary Letter No. 70-10*—However, where a Carrier makes an adjustment in its customary charge screen under Exception 1 (will be permitted only in individually identified and highly unusual situations where equity clearly indicates the increases are warranted.), the Carrier may record a new fee as a customary charge after it has been made by the physician or other person to patients generally, for at least three months.—In each instance in which

a customary charge profile is changed under exception 1, the Carrier must fully document the situation and its determination, and have such documentation readily available for review by the Bureau of Health Insurance."

"*Part B Intermediary Letter No. 72-13*—Implementation of Price Commission's Phase II Reasonable Charge Policy—(a) Where it has come to the Carrier's attention that a 1971 charge reflects a price increase that was made contrary to Phase II guidelines or Phase II Regulations of the Price Commission, the charge may not be used in calculating customary charges.—As explained in the April 7 teletype, if the standard updating procedure referred to above were followed without modification, the charges allowed under the Medicare Program would rise approximately 6.2 percent in the aggregate during fiscal year 1973. Therefore, to limit the aggregate increase to 2.5 percent as required by the Price Commission, only 40 percent (2.5 is about 40 percent of 6.2) of the increases that would ordinarily have been allowed can be recognized.

2. Equity Adjustments in Customary Charges In addition to the scheduled updating of customary charges, other adjustments in customary charge limits may be made currently and through fiscal year 1973 in individually identified and highly unusual circumstances *where the equity considerations outlined in Enclosure I are met. Such adjustments may apply prospectively only.*

C. Carrier Responsibility for Monitoring Compliance with Phase II Limitations.

—However, where a Carrier becomes aware of fee increases that appear to violate these policies, it should promptly report them, together with such supporting information as may be available to the Carrier, to the District Director of Internal Revenue for the area in which the violation occurred."

The Department of Health, Education and Welfare of Social Security provided all Carriers with a Medicare Part B Carrier's Manual, as an aid in the processing of claims. I find the following Sections to be applicable to this case:

"*5010.2 Equity Adjustments in Customary Charge Screens.*—Once a Carrier has established the customary charge screens for a fiscal year, further increases (other than to correct errors) will be permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. Request for revisions in customary charge profiles should be initiated only by physicians or other persons furnishing covered services. Such requests should be neither encouraged nor discouraged by the Carrier, and each request will have to be handled on the basis of its own merits. All of the following considerations are to be taken into account, as applicable, in determining whether unusual circumstances warrant a revision in a customary charge profile in a particular situation:

A. *The time that has elapsed since the last change was made in the customary charge.*—

This involves finding out how long it has been since the last change, and if the physician or other person has had a change in his customary charge for the service in the past two or three years. Generally, the more time that has elapsed since the last change the stronger the case is for recognizing the current change.

Where the physician or other person states he did not increase his fees because of the government's request for restraint in this regard, and the Carrier can verify this through its claims records and/or information furnished by the physician or other person, it may take this factor into account in determining whether unusual circumstances are present in a particular case.

B. *The size of the requested increase and the relationship of the new and old charges to the charges made by others for the service.*—The Carrier should consider the amount of the requested increase and the relationship of the new and old charges to the customary charges of other physicians in the locality for the service.

C. *Increases in the physician's or other person's operating expenses which are used to justify an increase in charges.*—Where the physician or other person specifically makes the point and is able to establish that increases in his operating expenses are substantially above those resulting from general economic factors, and he substantially [sic] the uniqueness of his situation, the Carrier may consider this factor in determining whether an adjustment in its customary charge profile is warranted.

These are not the only factors that may be considered by the carriers in determining whether unusual circumstances exist to permit a re-evaluation of a physician's or other person's customary charge profile. They merely illustrate the kind of analysis a Carrier should make in deciding whether a customary charge profile should be adjusted. Such adjustments should be applied *prospectively only*, i.e., on claims processed after the date the Carrier determined the equity adjustment was merited.

Except in situations in which the regulations or BHI instructions provide specific exceptions, the amount recorded as a customary charge limit for a service in a Carrier's screen must normally be the median of the charges made by the physician or other person for the service during a full one-year period. However, where a Carrier makes an equity adjustment in its customary charge screen under this exception, the Carrier may record a new fee as a customary charge after the charge has been made by the physicians or other person to patients generally, for at least three months.

Generally, each Carrier has the responsibility for determining whether an equity adjustment in a physician's or other person's customary charge profile can be made. In each instance in which an adjustment is made, the Carrier must document the situation and its determination, and have such documentation readily available for review by the Bureau of Health Insurance. Normally, equity adjustments should be made in customary charge profiles only in a relatively small number of situations."

"*5010.3 Customary Charge Profile.*—Each Carrier should establish and maintain in readily usable form adequate data on the customary charges for specific services and procedures made by individual physicians and other persons and organizations which render covered services. Any method used (e.g., electronic data processing techniques or manual-clerical operations) to store data is acceptable so long as the results provide accurate and readily available information. The customary charge record for each physician or other person or organization rendering covered services should include at least (a) his name, office address, identification code, locality identification, and specialty status; (b) a continuing history of his charges for specific services, supplies etc., and (c) a customary charge for each specific service or item which has been derived from his history of charges for that service or item (and which is to be used as the basis for the determination of reasonable charges in conjunction with the prevailing charge criterion). The Carrier should develop and include in the profile for the physician or other person a customary charge conversion factor for use with a relative value scale where it does not have sufficient data to establish the actual customary charge, or where an infrequently performed procedure is involved.

Where the record contains a charge made under unusual circumstances, the record should, if possible, include a description of these circumstances. Such a charge should, however, not be used in calculating the physician's or other person's customary charge for a service in situations to which the unusual circumstances do not apply."

CONCLUSION AND DECISION:

The Claimant's principle thrust in their challenging arguments to the Carrier's refusal to grant equity increases and/or adjustments retroactively would appear to be the fact that Intermediary Letter 72-13, which they allege to be the Carrier's "sole basis" for refusing to act retroactively, has been "obsoleted" since the publication of Intermediary Letter Listing of July 1974.

And yet, on August 30, 1976, Mr. Joseph J. Czarnecki, the Resident Representative of the Bureau of Health Insurance with the Carrier, wrote the following opinion:

> "A customary charge screen is designed to represent a maximum allowable amount that is based on the *previous* charging practices of a physician or supplier. Several BHI issuances presume this understanding, sometimes without explicitly stating it (I.L. 70-10, the 12/17/68 letter to all contractors, etc.). Your reference to I.L. 72-13 is good. Moreover, regulations [sic] 405.503 (d) is just as explicit, stating that the revised customary charge will be used as the screen for services rendered *after* the revision has been made. A practical approach would permit use of the screen to claims received after the revision has been made."

Addenda thereto, on November 10, 1976, in response to a request from Mr. Leonard A. Estin, Executive Vice President of Erika, for a change in Medicare's current method of determining customary and prevailing charges for home dialysis supplies; Mr. Saverio DeRosa, Contractor Officer, of the Regional

Bureau of Health Insurance in New York City, wrote the following response:

> "Medicare Law specifies that Carrier prevailing charge screens for any July through June period may not exceed the 75th percentiles of customary charges for services in the preceding calendar year. The law specifically defines the base year from which charge data may be derived for the purpose of calculating reasonable charges. Once customary charge screens have been established for a year, further increases (other than to correct mathematical errors made in the calculation of prevailing charge amounts) are permitted only in individually identified and highly unusual situations where equity clearly indicates that increases are warranted. However, since the law sets forth the manner in which prevailing charges are to be calculated as precisely as it does, the equity adjustment provision is applicable only to customary charges. Current costs and currently charged prices for supplies cannot be considered by the Carrier in their prevailing charge calculations. Thus, under the established reimbursement criteria, established prevailing charge screens must stand, unless it can be determined that the Carrier improperly obtains base year charge data or committed mathematical errors in the calculation of prevailing charge amounts. Therefore, the Carrier has no authority to revise prevailing charges or base them on current year charges.
>
> Erika does have the right to file for an equity adjustment for its customary charges, but according to Medicare regulations, *even if an*

equity adjustment is granted there would be no retroactive adjustment as you suggest."

The Hearing Officer believes Intermediary Letter 72-13 established the Bureau of Health Insurance historical precedent concerning equity increases and/or adjustments on a prospective basis only. Although subsequently declared "obsolete" it does not necessarily negate its historical precedent, as substantiated by the 1976 written opinions of Messrs. Czarnecki and DeRosa, both officials with the Bureau of Health Insurance, and the October 1976 revision of Section 5010.3 of the Part B. Medicare Carriers Manual.

The Carriers responded expeditiously when the request(s) for equity increase(s) and/or adjustment(s) were received regarding both CDAK #4 and Heparin. The Hearing Officer finds no legitimate basis for retroactive equity increases and/or adjustments . . . or any Social Security Administration regulations or instructions, stated or implied, which would dictate retroactive payments in such a situation.

The Hearing Officer hereby concurs with the Carrier's decision to grant equity increase(s) and/or adjustment(s) prospectively regarding both CDAK #4 and Heparin, and to deny equity increase(s) and/or adjustment(s) retroactively.

In accordance with Section 405.835 of the Federal Regulations, this decision is binding on all parties to these claim(s) and Hearing.

This is the twelfth day of March 1977.

HENRY A. HARTLEY
Hearing Officer

LISTING OF EXHIBITS

ERIKA, INC.—MEDICARE PART B FAIR HEARING

HEPARIN Equity Increase:

Exhibit 1 Claimant letter, dated May 18, 1976, to the Carrier.

Exhibit 2 Carrier Intra-Office Memos, dated May 20-25, 1976.

Exhibit 3 Carrier Intra-Office Memo, dated May 26, 1976, re. clarification.

Exhibit 4 Claimant letter, dated June 1, 1976, to Carrier.

Exhibit 5 Claimant letter, dated June 10, 1976, to Carrier.

Exhibit 6 Carrier letter, dated July 26, 1976, to Claimant.

Exhibit 7 Carrier Office Memo, dated August 18, 1976, re. phone call from Joseph Casson, Attorney for Erika.

Exhibit 8 Carrier letter, dated August 24, 1976, to Joseph Casson—with copy to David Smith, Director, Erika, Inc.

Exhibit 9 Carrier Memo, dated August 24, 1976, to Mr. Czarnecki, Resident BHI.

Exhibit 10 Reply from Mr. Czarnecki, Resident BHI, to Carrier.

Exhibit 11 Claimant letter, dated September 3, 1976, to Carrier.

Exhibit 12 Letter, dated November 10, 1976, from Mr. DeRosa, Contractor Officer, BHI, to Mr. Estin, Erika Executive Vice President.

Exhibit 13 Hearing Officer's letter, dated January 3, 1977, to Claimant scheduling Hearing for January 11, 1977—which was subsequently changed to February 11, 1977.

CDAK #4 HOLLOW FIBRE KIDNEY—Retroactive Price Adjustment

Exhibit 1	Claimant letter, dated February 5, 1976, to Carrier.
Exhibit 2	Claimant letter, dated August 4, 1976, to Carrier.
Exhibit 3	Carrier letter, dated August 16, 1976, to Claimant.
Exhibit 4	Claimant letter, dated September 3, 1976, to Carrier.
Exhibit 5	Letter, dated November 10, 1976, from Mr. DeRosa, BHI, to Claimant.
Exhibit 6	Hearing Officer's letter, dated January 3, 1977, to Claimant.

The following Exhibits were submitted subsequent to the February 11, 1977 Hearing.

February 25, 1977	Three page brief, with attachments, from Joseph Casson, Attorney.
March 1, 1977	Two page rebuttal brief from R. W. Giordano, Medical Administration.

END OF LISTING.

APPENDIX E

May 9, 1977.

Arent, Fox, Klintner, Plotkin & Kahn
Counsellors at Law
Federal Bar Building
1815 H Street, N. W.
Washington, D. C. 20006

Att: Joseph E. Casson, Esquire

Re : ERIKA, INC.
Request to Reopen.

Dear Mr. Casson:

May this acknowledge receipt of your recent correspondence regarding the above-entitled matter.

I am quite certain you are aware that Appeals and Hearing procedures regarding Medicare claims are held in strict compliance with the directives of the Bureau of Health Insurance, Social Security Administration, and the Department of Health, Education and Welfare.

Federal Regulations #5, Sub-part B, Section 405.841, provides: "Reopening initial or review determination of the Carrier and decision of a Hearing Officer may be reopened by such Hearing Officer". This regulation is further amplified by Section 12100.2 of the Part B Medicare Carrier Manual (DHFA-SSA, 14-3) which provides: ". . . conditions under which a . . . decision may be reopened." Section 12100.7 provides: "Good cause may be considered for reopening." Section 12100.8 provides: "New and material evidence includes any evidence which was not considered when the previous determination was made

and which shows the facts that *may* result in a conclusion from that reached in the determination."

Section 405.835 provides: "The Hearing Officer's decision shall be final and binding on all parties to the Hearing unless it is revised in accordance with Section 405.841"—which I quoted in the above paragraph. In essence, the law does not provide for an appeal to the Social Security Administration from the Hearing Officer's decision . . . or for judicial review by Federal or State courts.

After very careful examination and review of the entire claim file, Hearing transcript, and your recent correspondence—with attachments, I do not find any "good cause in the form of new and material evidence" which was not considered when the previous determination(s) was made on March 12, 1977, and I hereby Affirm that original determination. This decision is binding on all parties to the claim(s) and Hearing.

Sincerely,

/s/ Henry A. Hartley
HENRY A. HARTLEY

APPENDIX F

FORMAL HEARING PURSUANT TO TITLE XVIII, PART B, OF THE SOCIAL SECURITY ACT—("MEDICARE")

HIC # Not Applicable

IN THE MATTER OF: ERIKA, INC., One Erika Plaza, Rockleigh, New Jersey 07647, CLAIMANT

and

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, CARRIER

DETERMINATION OF HEARING OFFICER

Hearing held on the 10th day of January, 1973 at The Prudential Insurance Company Plaza Building on Broad Street in Newark, New Jersey.

Hearing Officer:

Henry A. Hartley

Appearances:

For the Claimant:

Arent, Fox, Klintner, Plotkin
& Kahn, Esqs.
By: Joseph E. Carson, Esq.
Attorneys for the Claimant

David Thomas Smith
Comptroller for Claimant

For the Carrier:

Raymond Merola,
Senior Claim Advisor, Medical
Administration-Medicare

Betty Willis,
Supv. Claims Consultant, Medical
Administration-Medicare

Dennis DeMorat,
Assistant Claim Consultant,
Medical Administration-Medicare

MATTER AT ISSUE:

Concerns Medicare's reimbursement policies and an equity increase/adjustment(s) request by the Claimant for home dialysis kits and other dialysis supplies. The amount(s) at issue are in excess of five hundred and eighty-six thousand, five hundred and eighty-three dollars ($586,583.00).

HEARING TESTIMONY:

The Claimant's representatives explained that ERIKA, Inc., through the sales of its "Di-Ala-Kit" supplies more than 50% of all patients on home dialysis in the United States, through a convenient and single source of supply. In order to perform a dialysis treatment approximately thirty different items are required. ERIKA purchases these supplies from various manufacturers in large quantities and accumulates the merchandise in its warehouses throughout the United States. Based on the patient's individual prescription, they break cartons into the required quantities and ship a "Di-Ala-Kit" containing the patient's exact requirements for 24 treatments on a standard eight week schedule.

ERIKA is reimbursed by the Carrier under Part B, the "Customary and Prevailing Charge" method. The claimant contended this method of reimbursement was primarily designed for physicians and other providers of services rather than distributors of supplies. Under this method the intermediary sets a charge screen based on the average of the prior years' actual invoices from the various providers in its geographic area. ERIKA is the only provider of its type in New Jersey and therefore, their prices determine the "screen".

ERIKA is a distributor of approximately 5,000 products from over 400 manufacturers, performing only ware-housing, packaging, distribution and customer service functions, and must be permitted to pass on price increases charged to ERIKA by the manufacturer, over which it has no control. Because of widespread inflation during the past several years, ERIKA has experienced a series of substantial price increase as well as an increase in its own operating costs. Without an opportunity to pass along these increases, ERIKA is required to provide this merchandise to patients at prices which do not allegedly even cover their cost prices. Since this situation is apparently unique and unforeseen in the regulations, the Claimant is requesting an adjustment to the "screen" method(s) used by the Carrier.

The Claimant testified that ERIKA relates to its status as a seller of medical supplies and equipment used by patients undergoing kidney maintenance dialysis in a home setting . . . who are self-dialysing at home. Allegedly, pursuant to Intermediary Letter 73-25, the method of calculating both the customary and prevailing charge(s) for ERIKA's reimbursement is intended to be covered by the normal reasonable charge rules rather than by the special rules estab-

lished for physicians' services. Analyzing the methodology that should apply to ERIKA's reimbursement should be the controlling regulations which govern the criteria for the determination of reasonable charges.

Therefore, if the methodology applied to ERIKA is analyzed in the light of the normal reasonable charge regulations, adjustments upward should have been made in the amount of reimbursement to ERIKA to reflect changes in the customary charge, and accordingly changes in the prevailing charges.. ERIKA's volume of activity within the geographic area served and used by the Carrier in determining prevailing charge(s) is sufficiently great that ERIKA constitutes both the customary and the prevailing charge(s) for the great majority of the supplies and equipment which are germaine to this present Hearing.

This anomaly results when ERIKA experiences increases from its suppliers, which would normally be reflected in the market place uniformly, and constitutes new prevailing charges, they are reflected as new customary charges for ERIKA and are controlled by the then existing prevailing charge(s), which is the previous customary charge of ERIKA. The Claimant contended there is substantial flexibility in the Medicare regulations governing reasonable charge(s), in addition to specific provisions within those regulations, that not only permit recalculation(s) of the charge limits for the reasonable charge for ERIKA and permits many of the increases it receives, which are an expected part of the process of calculating customary and prevailing charges.

It was testified that ERIKA supplies approximately fifty percent of Medicare patients, whereas, the remaining fifty percent are "private pay patients". The

Claimant periodically supplies the Carrier with supplements and amendments to their catalog, which reflect their price adjustments they are charging their "private pay patients". They contended that this notification to the Carrier constituted factual information that should have served as a basis for an adjustment in both the customary charge and the revaluation of the prevailing charge(s).

The Claimant characterized their "reseller status" as meaning that much of the equipment and supplies which it sells is purchased in manufactured forms from other unrelated companies, many of whom sell in the same general product market, although not necessarily in the same geographic market.

The Claimant contended that Section 1842-D of the Social Security Act . . . "has specific reference to the fact that in the case of medical services supplied and equipment charges incurred after December 31, 1972 determined to be reasonable, may not exceed the lowest charge levels when such services and equipment are widely available in a locality, except to the extent and under circumstances interpreted by the Secretary". The Claimant contended it makes reference to the fact of using comparable services supplied and equipment—and it authorizes the Secretary to vary that limit upward, if necessary, to reflect local conditions. Furthermore, Section 405.506 specifically contemplates the possibility of charges higher than the customary or prevailing charges.

The Claimant also contended that they had supplied sufficient information to the Carrier which, pursuant to applicable regulations, authorized the Carrier to adjust the customary charges of ERIKA, and

accordingly, the prevailing charges based on that factual information, reflected changes in the customary and prevailing charges within the market place, which revaluations are encouraged by the regulations. The Claimant specifically contended . . . "We don't believe that anything we are asking for requires the Carrier to go outside the present language of the regulations". Whereas, the Carrier consistently contended . . . "The Bureau has consistently told us to hold to the regulations which discuss customary and prevailing and revaluation on an annual basis".

The Claimant denied requesting carte blanche authority to present any price increases they receive to the Carrier, but rather there are circumstances when the right evidence is available and warrants the Carrier to make a determination other than at the calendar anniversary as to whether or not a particular customary or prevailing charge has changed and to respond to it. The Claimant contended there is both authority and encouragement to examine the circumstances during various intervals in the existing regulations which might support a change in the customary and prevailing charge(s). They alleged that the magnitude of review and verification is not a rationale for not doing it.

The Carrier respresentatives explained that reimbursement to suppliers is usually made on the basis of reasonable charge, which is determined by the customary charge of the supplier and the prevailing charge in a locality.

Medicare regulations specified that Carrier prevailing charge screens for any July through June period may not exceed the 75th percentiles of customary charges for the services in the preceding calendar year. Once

customary charge screens have been established for a year, further increases (other than to correct mathematical errors made in the calculation of prevailing charge amounts) are permitted only in individually identified and highly unusual situations where equity clearly indicates that increases are warranted. The law established the manner in which prevailing charges are to be calculated precisely as it does, the equity adjustment provision is applicable only to customary charges. Current costs and currently charged prices for supplies cannot be considered by the Carrier in their prevailing charge calculations. Under the established reimbursement criteria, established prevailing charge screens must govern, unless it can be determined that the Carrier improperly obtained base year charge data or committed mathematical errors in the calculation of prevailing charge amounts. The Carrier has no authority to revise prevailing charges or base them on current year charges.

APPLICABLE LAW, REGULATIONS AND GUIDELINES:

Title XVIII, Health Insurance for the Aged, and Public Law 89-97 of the Social Security Act, as amended, and quoted in part, provides:

> *Section 1842(a)* In order to provide for the administration of the benefits under this part . . . the Secretary is authorized to enter into contracts with Carriers . . . which will . . . (1) (A) make determinations of the rates and amounts of payment required pursuant to this part to be made to providers of services . . . on a . . . reasonable charge basis . . . (3) Each contract shall provide that the Carrier . . . (b) will take such

action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable . . . (E) . . . there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

Section 1871 The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title . . .

The Department of Health, Education and Welfare of Social Security provides all Carriers with a Medicare Part B Carrier's Manual, as an aid in the processing of claims. The following Sections, as amended, and quoted in part, provides:

25 DURABLE MEDICAL EQUIPMENT

25-1 HEMODIALYSIS EQUIPMENT—HOME USE

The following conditions must be met before payment can be made for the home use of such equipment:

1. The device is required because the patient had end-stage renal disease.
2. The equipment is appropriate for home use. There are various types of dialysate delivery systems which supply dialysis fluid to the dialyzers which contain the blood. Approved units are those dialyzers and dialysis delivery systems prescribed by recognized specialists at approved home hemodialysis training centers where the patients are trained.

Section 2100. DURABLE MEDICAL EQUIPMENT—GENERAL

Expenses incurred by a beneficiary for the rental or purchase of durable medical equipment (DME) are reimbursable if the following three requirements are met. The decision whether to rent or purchase an item or equipment resides with the beneficiary.

A. The equipment meets the definition of DME (Section 2100.1); and

B. The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the function of his malformed body member (Section 2100.2);

C. The equipment is used in the patient's home (Section 2100.3).
and

Chronic Renal Disease

Section 2230. TREATMENT OF CHRONIC RENAL DISEASE

Section 2231.1 Definition of Terms.—

A. *Chronic Renal Disease (CRD).*—Terminology—The term "end-stage renal disease" is the technically accurate term for that stage of chronic renal disease which requires a continuing course of dialysis or kidney transplantation to ameliorate uremic symptoms and maintain life. The term "chronic renal disease" alone does not describe this stage of renal disease completely because many chronic renal conditions do not require maintenance dialysis or kidney trans-

plant; however, the term end-stage may connote a terminal condition to patients not familiar with this language. The term chronic renal disease (CRD) is therefore, used in this manual with the understanding that in this context the reference is to chronic renal disease which requires hemodialysis or transplantation, as set out in the law. In correspondence with the public, it is recommended that a term such as "permanent kidney failure" be used, or "chronic renal disease," with the qualifying language of the law.

B. *Dialysis.*—A process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semipermeable membrane. There are two types of renal dialysis in common clinical usage, hemodialysis and peritoneal dialysis are acceptable modes of treatment of chronic renal disease.

1. *Hemodialysis.*—Where blood is passed through an artificial kidney machine and the waste products diffuse across a man-made membrane into bath solution known as dialysate after which the cleansed blood is returned to the patient's body.

2. *Peritoneal Dialysis.*—Where the waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically.

Section 5000. Reasonable Charges as a Basis for Payments

The reasonable charge is the basis of payments under the supplementary medical insurance program for medical and other health services furnished by physicians, medical groups, independent laboratories, suppliers of ambulance services, and suppliers of durable medical equipment, prostheses, etc.

In the administration of the medical insurance program, the Carrier has primary responsibility for determining reasonable charges. The careful determination of reasonable charges in a way which is equitable both to those rendering the services and to those paying the premiums is a very important responsibility. The possible impact on fees charged and general public is a matter of broad concern that should be considered in applying the criteria for determining reasonable charges. The amount of future premiums under the medical insurance program will be directly affected by Carrier performance in determining reasonable charges.

The reasonable charge determinations made by Carriers are not normally reviewed by the Bureau of Health Insurance on a case-by-case basis. However, the Bureau of Health Insurance has an overall responsibility for the administration of the supplementary medical insurance program. The basic methods and procedures used by Carriers in determining reasonable charges must therefore, be consistent with the law, the regulations, and the broad principles and policy guidelines issued.

The following guidelines are intended to assure overall consistency among Carriers with respect to the concepts they apply in making reasonable charge determinations.

Section 5002. CRITERIA FOR DETERMINING A A REASONABLE CHARGE

The two criteria set out in the Medicare law (Section 1842 of title XVIII) which must be considered in determining the reasonable charge for a service are: (a) *the customary charges* for similar services generally made by the physician or other person furnishing such services; and (b) *the prevailing charges* in the locality for similar services.

Therefore, the reasonable charge for a specific service (Section 5030.2), in the absence of unusual medical complications or circumstances (see Section 5024 and 5200ff.) may not exceed the lowest of: (a) the physician's or other person's customary charge for that service; (b) the prevailing charge made for similar services in the locality (however, see Section 5020.3); or (c) the actual charge of the physician or other person rendering the service (Section 5030).

The law also provides that the reasonable charge for a service may not exceed the charge applicable for a comparable service and under comparable circumstances to the policyholders or subscribers of the Carrier. (See Section 5026)

Also, under the law, other factors that may be found necessary and appropriate with respect to a specific item or service to use in judging

whether the charge is inherently reasonable, should be taken into account.

The income of the individual patient may not be considered in determining the amount of the reasonable charge. Consideration of a patient's income in determining the reasonable charge could be looked upon as an inverse means test—that is, it would result in a situation under which the Medicare program would pay more for beneficiaries with high incomes than it would pay for beneficiaries with low incomes. There is no provision in the Medicare law for a Carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

Section 5002.1 General Updating of Customary and Prevailing Charges.—

The customary and prevailing charge limits used by the Carriers should be *updated as early as possible at the beginning of each fiscal year (the 12-month period beginning July)*, using the available statistics on charge physicians and other persons have made for services derived from claims processed or from claims for services rendered during all of the immediately preceding calendar year. For example, the limits used during fiscal year 1972 (July 1, 1971 - June 30, 1972) were based on the charges made in calendar year 1970.

Before changes in reasonable charge screens can be implemented, the appropriate RO will, based on the data which it has reviewed and analyzed, notify the Carrier in writing as to whether or

not the screens are found acceptable. Final decision on any questions regarding the implementation of new screens will need to be made on an individual Carrier basis by the Bureau of Health Insurance.

Once the Carrier has made a general update of its customary and prevailing charge screens for a fiscal year, further revisions in these screens will not be permitted, during that fiscal year, except (1) as outlined in Section 5010.2; or (2) to correct erroneous calculations; or (3) to establish screens for new physicians/suppliers or new services. In no event may a corrected locality prevailing charge exceed the amount justified by the maximum allowable prevailing charge (calculated in accordance with Section 5020.3C), the no-rollback provision, and/or the Administrative Savings Clause. (See Section 5020.3E)

All date on the frequency of services, all data files and customary and prevailing charge files used to establish reasonable charge screens should be retained by the Carriers and be available for use, e.g., in implementing the economic index limitation on prevailing charges. It is especially important to retain the data for calendar year 1971 since this is the base year for applying the economic index limitation on prevailing charge increases.

Section 5010. THE CUSTOMARY CHARGE

The customary charge is the amount which best represents the actual charges made for a given medical service by a physician to his patients in general, or by other persons who supply other medical and health services to the general public.

The Carrier should therefore, obtain information on the customary charges of physicians and other persons not only from the Medicare Program, but from other available sources, e.g., from its own programs, from other insurance programs, from the Federal Employee Health Benefit Program, from CHAMPUS, from any studies conducted by State or local medical societies, and from public agencies. It also may ask physicians or other persons for their charges for services rendered to the public in general where the Carrier decides that circumstances will permit this.

In instances where physicians or other persons may feel that the Carrier does not have sufficient current information about their charges, they may volunteer this information to the Carrier. Further, Carriers should make known to the medical community their willingness to receive currently valid information regarding customary charges. However, any information on charges obtained from other sources should be validated, to the extent possible, against the Carrier's claims experience under Medicare and its own programs.

Section 5010. CALCULATING THE CUSTOMARY CHARGE.—

To the extent possible, when customary charges are calculated for a fiscal year, the actual charges physicians or other persons have made for services rendered during the calendar year immediately preceding the start of the fiscal year (i.e., derived from *either* claims processed, *or* from claims for services rendered during the preceding calendar year) must be used.

In calculating the customary charge for a given service, each charge the physician or other person has made for a service should be arrayed in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charge data should then be selected as the physician's or other persons customary charge for the service.

However, where the charge generally made by a physician or other person to other patients are lower than those made to Medicare beneficiaries, the lower charges should be used as the basis for establishing the Medicare reasonable charge screen.

In order to accurately reflect a physician's customary charging pattern, the Carrier should establish a minimum number of charges for the same service, i.e., three charges where two are identical, or four charges where each is different, in order to calculate a customary charge for that service. Carriers may apply other criteria where necessary in a particular case, but only with regional office approval.

When a Carrier does not have adequate statistics on charges for all of a calendar year, e.g., for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June 30 of that calendar year only may be used. The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during the calendar year.

Where a Carrier has permitted an increase in a customary charge under the unusual circumstances provision (See Section 5010.2), the increased amount should be recognized as the customary charge for the next fiscal year if it exceeds the median of the charges made by the physician or other person for the service during the calendar year immediately preceding the start of that fiscal year.

Section 5010.2 Equity Adjustments in Customary Charge Screens.—

Once a Carrier has established the customary charge screens for a fiscal year, further increases (other than to correct errors) will be permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. Request for revisions in customary charge profiles should be initiated only by physicians or other persons furnishing covered services. Such requests should be neither encouraged nor discouraged by the Carrier, and each request will have to be handled on the basis of its own merits. Generally, each Carrier has the responsibility for determining whether an equity adjustment in a physician's or other person's customary charge profile can be made. In each instance in which an adjustment is made, the Carrier must document the situation and its determination, and have such documentation readily available for review by the Bureau of Health Insurance. Normally, equity adjustments should be made in customary charge profiles only in a relatively small number of situations.

Section 5020. Determining the Prevailing Charge

Prevailing charges are those charges which fall within the range of charges that are most frequently and widely used in a locality for a particular procedure or service. The top of this range establishes an overall limitation on the charges which the Carrier should accept as reasonable for a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge (Section 5024).

For any fiscal year, the prevailing charge limit in a locality for a service must be calculated as the 75th percentile of the customary charges determined for that service in accordance with Section 5010.1. (However, see Section 5020.3 regarding the economic index limitation). In this calculation, each customary charge for the service should be arrayed in ascending order and weighted by how often the physician or other person rendered the service (as reflected by the charge data the Carrier used to calculate the customary charge). The lowest customary charge which is high enough to include the customary charges of the physicians or other persons who rendered 75 percent of the cumulative services is then to be determined as the prevailing charge for the service (subject to the economic index limitation).

Section 5020.1 Determination of Locality

For the purpose of making reasonable charge determinations, a locality is the geographic area for

which the Carrier is to derive the prevailing charges for services, usually a locality will be a political or economic subdivision of a State, and it should include a cross-section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service area (interstate or otherwise), comparable in concept to "trade areas".

Carriers should delineate localities on the basis of their knowledge of local conditions. The localities may differ in population density, economic level, and other major factors affecting charges for services. However, distinctions between localities should not be so finely made that a locality includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city).

Section 5100. OTHER HEALTH AND MEDICAL SERVICES

The supplementary medical insurance program provides for reimbursement on a reasonable charge basis for other medical services and items listed in Section 2000ff.

Instructions pertaining particularly to the determination of reasonable charges for covered items and services will be developed, as necessary and included in this chapter. However, the guides for the determination of reasonable charges and the statutory requirement that reasonable

charges determined on the basis of the applicable customary and prevailing charge criteria also apply to these items and services.

Section 5100.1 Determining Reasonable Charge for Packaged Dialysis Supplies.

In making this determination, the Carrier should compare the package charge to the charge for covered individual package components from the *same* supplier. If the total for covered items would entitle purchaser to a quantity discount in the supplier's traditional manner of doing business the discount should be subtracted. Where the supplier provides only packages and has no individual item charges, the Carrier should use its own discretion in selecting charge data from other suppliers for use in making the charge determination.

The following Regulations of the Secretary of Health, Education and Welfare, promulgated for the Administration of Supplementary Medical Insurance Program, as amended and quoted in part, provides:

405.501.. Determination of Reasonable Charges.

Payment for medical and other health services (See Section 405.251) furnished by physicians or other persons (except for services furnished by group practice prepayment plans electing cost reimbursement and certain services furnished by, or under arrangements made by, a provider of services) is made on the basis of the "reasonable charge" for such service which is determined by the Carriers selected by the Secretary to assist in the administration of the supplementary medical insurance program.

405.502 Criteria for Determining Reasonable Charges.—

(a) Criteria.—The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other person as well as others in the locality. The two criteria set out in the law which are considered in determining reasonable charges are:

(1) The *customary charges* for similar services generally made by the physician or other person furnishing such services; and

(2) The *prevailing charges* in the locality for similar services.

405.503 Determining Customary Charges.

—(a) Customary Charge Defined.—The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service.

—(d) Revision of Customary Charge.—A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the Carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary

charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. *If the new customary charge is not above the top of the range of prevailing charges (See Section 405.504(a)), it should be deemed to be reasonable by the Carrier,* subject to the provisions of Section 405.508.

405.504 Determining Prevailing Charges.—

(a) Range of Charges.—The term "prevailing charges" refers to those charges which fall within the range of charges most frequently and most widely used in a locality for particular medical procedures or services. The top of this range establishes, except as provided in Section 405.506, an overall limitation on the charges which a Carrier will accept as reasonable for a given medical procedure or service. Prevailing charges are derived from the overall pattern existing within a locality. For example, in a given locality the Carrier may find that the charges most frequently and widely used by physicians for a particular medical procedure range from $150 to $175. If in another locality the Carrier finds that the prevailing charges are different for the same procedure, then a different range of charges would be applied in making reasonable charge determinations for that locality. An acceptable method for the Carrier to objectively determine the point at which such limitation is established would be the use of the mean (arithmetic average) of the customary charges of physicians or

other persons in the locality for a given medical procedure or service, plus one standard deviation above the mean, rounded to the nearest dollar. However, the Carrier will adopt an appropriate limit for each procedure or service with judgment being exercised to assure that with respect to each particular array of data the result reached is reasonable. If, for example, there is a point just above the standard deviation which represents the amount charged by a substantial number of physicians in the locality, the limitation might, in such a situation, be established so as to include this point. On the other hand, the "trailing off" of an appreciable number of charges above the mean plus one standard deviation might not justify an upward adjustment.

The "standard deviation" is a basic statistical measure widely used in dealing with variations from a central tendency or norm. Its advantage over the approach that the "prevailing charge" is to include a fixed percentage of all charges lies in the fact that the standard deviation is flexible rather than rigid. It takes into account and is responsive to differences in the spread that exists in the underlying data.

(b) Variation in Range of Prevailing Charges. —The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the Carrier in

its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

(c) Reevaluation and Adjustment of Prevailing Charges.—Determinations of prevailing charges by the Carrier are to be reevaluated and adjusted from time to time on the basis of factual information about the charges made by physicians and other persons to the public in general. This information should be obtained from all possible sources including a Carrier's experience with its own programs as well as with the supplementary medical insurance program.

405.505 Determination of "Locality".—

"Locality" is the geographical area for which the Carrier is to derive the prevailing charges for services. Usually, a locality will be a political or economic subdivision of a State. It should include a cross section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to "trade areas". Localities may differ in population density, economic level, and other major factors affecting charges for services. Carriers therefore, shall delineate "localities" on the basis of their knowledge of local conditions. However, distinctions between

localities are not to be so finely made that a "locality" includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city).

405.506 Charges Higher Than Customary or Prevailing Charges.—A charge which exceeds either the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or both, may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. On the other hand, the mere fact that the physician's or other person's customary charge is higher than prevailing would not justify a determination of reasonable charge higher than the prevailing charge.

405.508 Determination of Comparable Circumstances; Limitation.—(a) Application of Limitation.—The Carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the Carrier would be obligated to pay. Under certain circumstances, some Carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individu-

als. Payment under the supplementary medical insurance program would not be limited to these lower amounts.

(b) When Comparability Exists.—"Comparable circumstances," as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the Carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:

(1) The Carrier bases payment under its program on the customary charges, as presently constituted, of physicians or other persons and on current prevailing charges in a locality, and

(2) The determination does not preclude recognition of factors such as specialty status and unusual circumstances which affect the amount charged for a service.

(c) Responsibility for Determining Comparability.—Responsibility for determining whether or not a Carrier's program has comparability will in the first instance fall upon the Carrier in reporting pertinent information about its programs to the Social Security Administration. When the pertinent information has been reported, the Social Security Administration will advise the Carrier whether any of its programs have comparability.

Responding to an ERIKA, Inc. request for an equity increase and/or adjustment for split home dialysis kits and other dialysis supplies; on June 14, 1977,

Mr. Henry J. Hehir, Director, Provider and Medical Services Policy, Bureau of Health Insurance, Social Security Administration, at Baltimore, Maryland, wrote Joseph E. Casson, Esquire, Counsel for ERIKA, Inc. (in part) as follows:

"In an exchange of correspondence (copies enclosed) between our New York health insurance regional office and ERIKA on this issue in 1976, Mr. Savario De Bosa explained the statutory constraints that are imposed on prevailing (illegible) levels, once they are established each July 1. He also noted that once customary charge screens are established, further increases (except to correct obvious errors) are permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. Since Mr. De Rosa did not furnish particulars on equity adjustments for customary charges, I am enclosing a copy of the policy guidelines Carriers are required to follow when determining whether such an increase is warranted. However, it *should be understood that any increases in the customary charge screens for ERIKA's supplies would not affect the current program payments it presently receives. The reason for this is that the established customary charges for ERIKA's various supplies are equal to the prevailing charges for these items. And, as you know, the prevailing charge levels set the program reimbursement limits for covered medical services and supplies under Part B of Medicare.*

Our understanding of the alternative method of payment you discussed with Mr. Pyles is illustrated by the following:

Example

A supplier charges a patient $700 for a dialysis kit containing five covered items for which the total Medicare reasonable charge, if the items were purchased separately, would be $800. When processing the claim for the kit, the Medicare Carrier determines that $700 is the reasonable charge for the kit. On the next shipment, the supplier sends only four of the five covered items, and the reasonable charge is determined to be $600 (based on the total reasonable charges that can be allowed for the four items when purchased separately).

Under your suggested alternative, since the reasonable charge for the omitted item when purchased individually ($200) was equal to one-fourth of the total reasonable charge for *all* items when purchased individually ($800), a "reasonable charge" of $625 for the "broken" kit would be derived. This would be done by reducing the $800 by the product of one-fourth of the kit price ($800 minus ¼ x $700 = $800 — $175 = $625).

The amount resulting from the calculation illustrated above exceeds (by $25 in the example) the sum of the reasonable charges for the covered items actually included in the "broken" kit and, therefore, could not be allowed under the provisions of section 1842(b)(3) of the Medicare law. We should also add that if the Carrier were to determine the reasonable charge for a "broken" kit by making proportional adjustments in the reasonable charge for the basic kit, the amounts allowed would be less than Prudential is currently allowing your client. In the above example, it could be reasoned that since the basic kit

had a reasonable charge of $700 and the item omitted was equal to one-fourth of the reasonable charge for all five items, the reasonable charge for the "broken" kit would be $800 minus one-fourth of $700, or $525. The following discussion should help you to understand the guidelines Carriers use in determining the reasonable charge for a dialysis kit.

Supplies such as dializers, venous and arterial sets, dialysate, saline solutions, administration sets, fistula needles and Heparin are covered items when required for the effective operation of a home dialysis machine. Conversely, supplies not necessary for the operation of the machine (even though they are necessary for the patient's well being) such as syringes, alcohol wipes, adhesive tape, bandages, alcohol, betadine, and underpads are generally noncovered items. *However, regardless of whether such noncovered items are included in a package with covered items, the reasonable charge for Medicare reimbursement purposes will be the lesser of the total of individual reasonable charges for all covered items in the package when purchases* [sic] *separately in comparable quantities, or the package charge. This rule applies whether the package (kit) is "broken" or not.*

In making this determination, the Carrier will compare the package charge to the reasonable charges for covered individual package components from the *same* supplier. If the total for covered items would entitle purchasers to a quantity discount in the supplier's traditional manner of doing business, the discount is subtracted. Where the supplier provides only packages and has no individual item charges, the Carrier will use its own discretion in selecting charge data from other suppliers for use in making the charge determination.

As an example of a package of home dialysis supplies for a 2-month period . . . the supplier's charge of $705 for the package in this instance is less than the sum of charges for individual covered components if purchased separately and, hence, is the reasonable charge.

The objective underlying the above rule was to assure that the beneficiary would be able to receive from one source all the necessary items in a single shipment that would be needed in performing the vital home dialysis treatments over a period of time, e.g., 2 to 3 months. It was anticipated that shipments in this fashion would enable the suppliers to realize cost savings which they could pass along to the beneficiary in the form of a single, package rate. And, once the reasonable charge for the basic package of supplies or kit was established, it would be administratively easy for a Carrier to process the subsequent claims for the basic kit. However, as we have indicated above, whether the basic dialysis supply kit is broken, or not, the reasonable charge cannot exceed the total amount that would have been determined to be reasonably by the Carrier if the individual *covered* items it contains had been furnished to the patient on an individual item basis.

I trust this explanation will help clarify the reasonable charge rules as they are applied to the pricing of both a basic dialysis supply kit and one that is "customized", i.e., "broken". I regret our statutory authority does not extend to the kind of pricing you suggest."

Addenda thereto, on November 10, 1976, in response to a request from Mr. Leonard A. Estin, Executive Vice President of ERIKA, for a change in

Medicare's current method of determining customary and prevailing charges for home dialysis supplies; Mr. Saverio De Rosa, Contractor Officer, of the Regional Bureau of Health Insurance in New York City, wrote the following response:

> "Medicare Law specifies that Carrier prevailing charge screens for any July through June period may not exceed the 75th percentiles of customary charges for services in the preceding calendar year. The law specifically defines the base year from which charge data will be derived for the purposes of calculating reasonable charges. Once customary charge screens have been established for a year, further increases (other than to correct mathematical errors made in the calculation of prevailing charge amounts) are permitted only in individually identified and highly unusual situations where equity clearly indicates that increases are warranted. However, since the law sets forth the manner in which prevailing charges are to be calculated as precisely as it does, the equity adjustment provision is applicable only to customary charges. Current costs and currently charged prices for supplies cannot be considered by the Carrier in their prevailing charge calculations. Thus, under the established reimbursement criteria, established prevailing charge screens must stand, unless it can be determined that the Carrier improperly obtained base year charge data or committed mathematical errors in the calculation of prevailing charge amounts. Therefore, the Carrier has no authority to revise prevailing charges or base them on current year charges.

CONCLUSION AND DECISION:

The Claimant's principle thrust in their challenging arguments to the Carrier's refusal to grant equity increases and/or adjustments would appear to be: (1) that a proper application of the rules and regulations of the Medicare Program require upward adjustments in both the customary and prevailing charges for ERIKA to reflect the increases in ERIKA's catalog prices; (2) that a sufficient non-Medicare market exists on which to predicate an accurate and current prevailing rate for ERIKA's products; (3) sufficient evidence has been presented to establish that ERIKA has increased its customary charge to its current catalog prices; and (4) that nothing in the Medicare rules and/or regulations operate to prevent these adjustments. Succinctly stated by ERIKA's counsel at the Hearing . . . "We don't believe that anything we are asking for requires the Carrier to go outside the present language of the regulations."

However, and pursuant to the very specific Medicare law, regulations and guidelines, hereinbefore outlined, and augmented by the written opinions of Mr. Henry J. Hehir, Director, and Mr. Saverio De Rosa, Contractor Officer, of the Bureau of Health Insurance; the criteria for Medicare reimbursement is the provider's customary or the prevailing fee, whichever is lower. Furthermore, once prevailing fees are established each year, they cannot be changed, unless an error in calculation is detected.

A valid prevailing fee usually requires at least five providers. However, exceptions can and were made in home renal dialysis supplied because: (1) ERIKA was and is the sole provider in the State of New

Jersey; (2) although other sources in New Jersey could be used, none were available; and (3) although there are similar providers nationwide, the Medicare law precludes establishing prevailing fees by sources outside New Jersey.

Therefore, prices in ERIKA's catalog were used for both customary and prevailing fees by the Carrier. Since reimbursement cannot exceed prevailing fees, and prevailing fees cannot be increased, the Carrier refused the Claimant's request for general increase in their supplies.

The Claimant had also apparently requested a revision of Medicare's reimbursement policy regarding their split kits of renal supplies, contending that the percentage be calculated of the charge for an omitted item to the total charge of all the components if purchased individually. The calculated percentage should be used in calculating the deduction for the omitted item from the package price. This would result in a greater allowance than under the present reimbursement method.

Part B Medicare regulations requires that the reasonable charge reimbursement must be the lesser of the total individual reasonable charge for all covered items in the package when purchased separately in comparable quantities, or the package charge. This rule applies whether or not the package is broken. If one eligible item is omitted from the package, that individual amount must be deducted from the package or kit cost.

The Hearing Officer has therefore, concluded, under the current Medicare law, regulations and guidelines, that the Carrier decided correctly in having denied the Claimant's request for an equity increase/adjust-

ments for home dialysis kits and other dialysis supplies. Pursuant to Section 405.860 (Authority of the Hearing Officer) of the Federal Regulations, the Hearing Officer hereby affirms and concurs with the Carrier's decision.

In accordance with Section 405.835 of the Federal Regulations, this decision is binding on all parties to this claim(s) and Hearing.

This is the seventh day of February, 1978.

HENRY A. HARTLEY
Hearing Officer

Exhibit 1 04/18/77—Letter from H. McCann, R.M., ERIKA to Mr. Risley, Medicare, requesting an increase in allowances for supplies for home renal dialysis beneficiaries.

Exhibit 2 04/27/77—Letter from H. McCann, R.M., ERIKA to Mr. Risley requesting increases in allowances for additional supplies (2).

Exhibit 3 05/03/77—Letter to Ms. McCann, ERIKA, for price information from Mrs. Willis, Medicare.

Exhibit 4 05/14/77—PRR referral for requested price information.

Exhibit 5 05/19/77—PRR reply—information will be furnished as soon as possible.

Exhibit 6 06/14/77—Letter from Ms. McCann to Mrs. Willis re: previous notice of increase to prevailing market price, our 5/3 letter, ERIKA's policy is to utilize the manufacturer's suggested resale price in their price determination.

Exhibit 7 06/14/77—Letter to Mr. Casson, Counsel for ERIKA, from Mr. H. Hehir, Director, Prov. and Med. Serv. Pol., BHI. Letter discusses:

1. Equity increase request—reply is that ERIKA's charges are prevailing and prevailing cannot be increased.

2. Alternative method of payments for kits suggested by ERIKA—would like percent of separate costs and subtract by that percent from the kit price. Per BHI guidelines—reimbursement must be the lesser of total individual charges or the "kit" price. Omitted items from the "kit" will be subtracted from the package price using individual charges by same supplier's price list for item omitted.

Exhibit 8 06/29/77—Letter from Mr. Casson to Medical Administration Division, Prudential—requesting fair hearing and mentioned claims filed with

Medicare for review of disallowed amounts on home dialysis (all had been returned to ERIKA). Fair hearing requested on grounds of delay in reviewing those claims (405.821 in regulations).

On 07/13/77, Mr. Risley called Mr. Casson to discuss letter—Mr. Casson indicated he wants to file suit against the government and before doing so, must go through Adm. Mr. Casson will send letter waiving right to informal review in order to expedite hearing process.

Exhibit 9 Letter to Ms. McCann, ERIKA, from Mrs. Willis, Medicare, in reply to her 06/14/77 letter criteria for determining Medicare's allowance is the lower of customary or the prevailing. Since their fees are equal to prevailing, no increase can be considered.

Exhibits 11-17 Exchange of correspondence between the Hearing Officer and ERIKA, Inc. legal counsel, re: scheduling a mutually convenient time and date for the Fair Hearing.

Exhibit 18 The Hearing Officer received (January 30, 1978) from Joseph E. Casson, Esquire, Counsel for ERIKA, Inc.:

(1) A copy of ERIKA's October 20, 1976 submission to The Prudential; and

(2) Copies of all regulatory and statutory provisions which Mr. Casson believes grants the Carrier sufficient authority to make the adjustments requested.

END OF LISTING.

APPENDIX G

EXCERPTS FROM THE MEDICARE CARRIER'S MANUAL

5010.1 *Calculating the Customary Charge.*—To the extent possible, when customary charges are calculated for a fee screen year, the actual charges physicians or other persons have made for services rendered during the calendar year immediately preceding the start of the fee screen year (i.e., derived from *either* claims processed *or* from claims for services rendered during the preceding calendar year) must be used.

In calculating the customary charge for a given service, each charge the physician or other person has made for a service should be arrayed in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charge data should then be selected as the physician's or other person's customary charge for the service.

However, where the charges generally made by a physician or other person to other patients are lower than those made to Medicare beneficiaries, the lower charges should be used as the basis for establishing the Medicare reasonable charge screen.

The carrier should establish three charges as the minimum number of charges for the same service needed to calculate a customary charge for that service.

When a carrier does not have adequate statistics on charges for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June

30 of that calendar year only should be used. The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during the calendar year.

Where a carrier has permited an increase in a customary charge under the equity provision (see § 5010.2), the increased amount should be recognized as the customary charge for the next fee screen year if it exceeds the median of charges made by the physician or other person for the service during the calendar year immediately preceding the start of that fee screen year. The increased amount is the correct customary charge for use in the appropriate prevailing charge calculation(s).

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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA,
PETITIONER,

v.

ERIKA, INC.,
RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF IN OPPOSITION

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Questions Presented

1. Does the Court of Claims have jurisdiction under 28 U.S.C. §1491 to adjudicate a claim that a Medicare intermediary has violated the Constitution or federal statutes in determining benefits payable under Part B of the Medicare Act, 42 U.S.C. §1395j *et seq.*?

2. When Congress enacted 42 U.S.C. §1395ff, did it by implication partially repeal the Tucker Act, 28 U.S.C. §1491, to eliminate Court of Claims jurisdiction over constitutional and statutory challenges to Part B Medicare determinations?

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UNITED STATES OF AMERICA,
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ERIKA, INC.,
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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF IN OPPOSITION

Respondent Erika, Inc. hereby opposes the petition for a writ of certiorari filed by the Solicitor General on behalf of the United States in this case.

Statutes Involved

28 U.S.C. §1491:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States

> founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort .... To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just ....

42 U.S.C. §§ 405(h), 1395u and 1395ff are reproduced at Appendix A-1 *et seq.*

Statement of the Case

The only issue before this Court is whether the Court of Claims had jurisdiction to adjudicate the claim of Erika, Inc. ("Erika") that payments due it from the Government under Part B of Medicare were limited or reduced in violation of the Medicare statute and the Constitution.

The Medicare Program is divided into two parts. Part A is a hospital insurance program which covers all qualifying persons. Part B is a voluntary supplemental insurance program. Coverage under both parts extends to any covered person, regardless of age, who requires kidney maintenance dialysis. 42 U.S.C. § 426(e).

Part A, 42 U.S.C. §§1395c to 1395i-2, pays the costs of inpatient hospital services and extended care services. *Id.* §§ 1395c, 1395d.

Part B, 42 U.S.C. §§ 1395j-1395w, generally relates to non-hospital providers such as physicians. *Id.* §§ 1395l, 1395x(s).

Part B benefits are administered by insurance carriers, pursuant to contracts entered into with the Secretary of Health and Human Services.[1] *Id.* §1395u. The carriers determine reasonable charges for services provided to the beneficiaries. 80 per cent of those charges are paid to the beneficiaries or to the providers as assignees of the beneficiaries. *Id.* The statute provides for "a fair hearing by the carrier" if a dispute arises over payment and the amount in controversy is $100 or more. *Id.* § 1395u(b)(3)(C). There is no express provision for review of the carrier's decision as to reasonable charges by the Secretary or any governmental agency.

Erika is a major distributor of kidney dialysis equipment and supplies. As an assignee of its customers/patients, Erika billed its carrier, The Prudential Insurance Company of America ("Prudential"), for sales of covered products to patients eligible for coverage under Part B. Under 42 U.S.C. § 1395u(b)(3), Prudential was to determine the "reasonable charges" for those products and to pay Erika 80 per cent of the "reasonable charges."

Erika's petition sought a money judgment in the Court of Claims to correct Prudential's unlawful and unconstitutional method of setting Erika's "reasonable" charge levels. Erika claimed, and the Court of Claims found on the basis of undisputed facts:

(1) that Prudential, in setting the level of "reasonable charges" for Erika, consistently engaged in a practice directly in violation of the Medicare statute; and

(2) that Prudential had specifically relied on a directive which was acknowledged to be obsolete and which never purported to cover the years in question.[2]

Prudential had thus engaged in practices directly violative of federal law (and its contract with the Government) in its treatment of Erika's Part B claims. Prudential's statutory (and

[1] Or his predecessor, the Secretary of Health, Education and Welfare.

[2] Erika asserted other claims, including constitutional claims, but the above are the only claims as to which the Court of Claims granted relief. The Court of Claims did, however, exercise jurisdiction to resolve those other claims on their merits.

contractual) violation was so substantial and so obvious that it warranted unanimous summary judgment by the full bench of the Court of Claims. In his concurring opinion Judge Nichols was moved to describe Prudential's actions as "virtual spoliation."[3] (P-26a)[4]

In the United States' statement of the case (Petition at 4) the United States defines the jurisdictional issue in manner more reflective of advocacy than accuracy. It asserts that:

> "The issue in this case is whether the Court of Claims has jurisdiction under 28 U.S.C. (& Supp. III) 1491 *to review the amount of benefits* payable under Part B of the ... [Medicare Act] ... for particular medical and other health services." (emphasis added). (Petition at 4)

That statement of the issue to a great extent begs the question.

The jurisdictional question actually decided by the Court of Claims, and hence the issue before this Court, was much narrower than the United States' statement suggests, and in fact the broader issue raised by the United States was determined by the Court of Claims in part in the *government's* favor.

The United States has sought to characterize Erika's claim as nothing more than a dispute over what are "reasonable charges" for particular services. (P-9a). The United States asserted that the legislative history of section 1395ff evidences

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[3] During the pendency of the Government's motion for rehearing, which related to a portion of the Medicare Carriers Manual not directly in issue in the case, Erika's counsel was informed by counsel for the United States that if the motion for rehearing were allowed, Prudential would use that determination to avoid correcting the statutory violation found by the Court of Claims. (App. A-9). Erika brought this to the attention of the Court of Claims (id.), which inserted a final paragraph into its Order on rehearing to prevent Prudential from acting in that fashion. P-32a-33a. The Carrier's attempted action in this regard was consistent with the type of behavior to which Judge Nichols referred.

[4] References to material in the appendix to the Petition are denoted "P-1a", etc. References to the appendix hereto are denoted "A-1", etc.

a clear Congressional intent to bar judicial review of those specific benefit determinations under Part B of Medicare.

The Court of Claims agreed with much of what the United States had asserted. For example, it acknowledged the statutory history of section 1395ff as indicating

> "... that Congress intended to bar judicial review of the amount of a particular benefit determination — as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services." (P.-14a)

That acknowledgement was not dispositive of Erika's claims since the Court viewed this action not as one for review of "thousands" of Part B "reasonable cost" determinations but rather as an action for sums due Erika from the United States as a matter of statutory and contractual right.

The Court of Claims, sitting *en banc*, therefore unanimously held that it had jurisdiction to adjudicate Erika's claims of statutory and constitutional violations in the determination of Part B benefits. Contrary to the United States' statement of the issue, however, the Court in no way sought to exercise jurisdiction to review specific "reasonable charge" determinations. Consistent with that limited view of its jurisdiction and in order not to encroach on areas left to Prudential's discretion and expertise in setting reasonable charge levels, the Court of Claims remanded to Prudential for determination of the amount of damages. (P-17a-18a, 21a).

Argument

I. The Court of Claims' Decision is Consistent with its Statutory Jurisdiction

A. *The Court of Claims has Jurisdiction Over Claims for Medicare Benefits.*

Under the Tucker Act, 28 U.S.C. §1491, the Court of Claims has jurisdiction to render judgment upon any claim

against the United States founded upon the Constitution, federal statute or regulation, express or implied contracts, or in other cases not sounding in tort. The Tucker Act is only jurisdictional, however, and any substantive right to money damages from the United States must be derived from contracts or other statutes. *United States* v. *Testan*, 424 U.S. 392, 398 (1976).

In this case, Erika's substantive right to money damages is both contractual and statutory. Having sold and delivered goods and services to beneficiaries under Part B, and having received assignments of those beneficiaries' claims for payment from Prudential, Erika has a contractual claim for benefits under Part B. *See Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980). Prudential's obligation to pay Erika in conformity with the statute is contractual as well. *See* 42 U.S.C. §1395u. Even taking Erika's claim as only a contractual one, therefore, the Tucker Act gives the Court of Claims jurisdiction.

Whether Erika has a right to money damages as a statutory claim depends on whether any federal statute "can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained." *United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport S.S. Corp.* v. *United States*, 178 Ct. Cl. at 607, 372 F. 2d at 1009. The Medicare legislation, fairly read, mandates appropriate payment to providers. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977); see P-11a.

Even though a carrier is the contractor/obligor, the United States is the real party in interest in disputes over entitlement to Part B benefits. *Kuenstler* v. *Occidental Life Ins. Co.*, 292 F. Supp. 532, 535 (C.D. Calif. 1968).

The Court of Claims has repeatedly held that 28 U.S.C. §1491 confers jurisdiction upon it to resolve claims for Medicare reimbursement, including claims by providers for reimbursement, unless specific legislation provides that

judicial review is available exclusively elsewhere (or review is clearly precluded in the Court of Claims). *Appalachian Regional Hospitals, Inc.* v. *United States*, 217 Ct. Cl. ____, 576 F.2d 858, 861 (Ct. Cl. 1978); *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347, 350-51 (Ct. Cl. 1976), *cert. denied*, 430 U.S. 969 (1977). Thus, unless Congress has acted to preclude actions in the Court of Claims relating to Part B benefit determinations, such actions are within the Court of Claims' jurisdiction.

The United States' jurisdictional argument in essence is that Congress has carved out an exception to that general grant of jurisdiction. None of the Congressional actions referred to by the United States, however, deprived the Court of Claims of its jurisdiction under the Tucker Act to decide this case.

B. *Congress did not Preclude Review of Part B Benefit Determinations in the Court of Claims*

The United States' contention that Congress deprived the Court of Claims of jurisdiction in this matter rests on two arguments:

1. That while 42 U.S.C. § 1395ff provides for judicial review of certain Part A benefit determinations and administrative review by the carrier as to the amount of Part B benefits, it is silent as to judicial review of Part B benefit determinations. The United States argues that Congress thereby intended to preclude all judicial review of Part B determinations, citing legislative history suggesting that the decision not to include statutory language permitting judicial review was deliberate.

2. That Section 205(h) of the Social Security Act, 42 U.S.C. § 405(h), through 42 U.S.C. § 1395ii, precludes all judicial review of the carrier's determinations under Part B.

The burden on the United States to establish preclusion is a very heavy one: it must provide "clear and convincing" evidence of congressional intent before this Court will construe a statute to restrict access to judicial review. *Johnson* v.

Robison, 415 U.S. 361, 373-74 (1974). Moreover, the United States is seeking to have a statute which denies judicial review in one forum read by implication to deny judicial review in all other forums. See P-25a-26a.

1) *42 U.S.C.* § 1395ff Does Not Deprive the Court of Claims of Jurisdiction in this Matter.

42 U.S.C. § 1395ff provides, in pertinent part, that an individual dissatisfied with a determination by the Secretary as to:

> (1) whether he or she is eligible under Part A of Medicare,
>
> (2) whether he or she is eligible under Part B of Medicare, or
>
> (3) the amount of benefits under Part A,

is entitled to an administrative hearing by the Secretary and judicial review of the Secretary's final decision. The statute expressly states that no judicial review of the Secretary's determination of the amount of Part A benefits is available if the amount in controversy is less than $1,000.

Because section 1395ff is silent regarding administrative or judicial review of determinations as to the amount of Part B benefits, the United States has argued that it implicitly precludes all judicial review of Part B determinations.

Section 1395ff mandates certain procedures to be followed and decisions to be made by the Secretary. Therefore the simplest and most reasonable explanation for its silence as to judicial review of Part B benefit determinations is that such determinations are to be made by carriers, not by the Secretary. See 42 U.S.C. §1395u; Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55 (1965). It is another section of the statute which requires carriers to have their own review proceeding completely distinct from the administrative hearings provided in section 1395ff. 42 U.S.C. §1395u(b)(3)(C). The carrier is required to:

> establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy .... (*id.*)

The absence of a specific authorization under section 1395ff for administrative and judicial review of decisions regarding the amount of Part B benefits is thus consistent with the fact that there is to be no decision by the Secretary on those issues. A carrier makes those determinations, and hearings by the carrier are provided for in section 1395u, not 1395ff.

Moreover, while Congress in Section 1395ff *expressly* precluded judicial review of certain classes of disputes, it was silent as to judicial review of Part B benefit determinations. Silence on this issue in section 1395ff cannot be taken to be the equivalent of Congress' affirmative preclusion of judicial review of other cases in the same section.

The United States argues, however, that in the legislative history of section 1395ff, the Senate Committe on Finance made the following parenthetical comment to the description of the requirements of hearings by the Secretary contained in section 1395ff:

> ... (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A.) ....

Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55 (1965).

This statement is far from an unambiguous withdrawal of jurisdiction. Administrative remedies under Part B were in fact provided in another section of Title 42 (§1395u) and at most the legislative history quoted above indicates that the bill was deliberately silent as to judicial review of Part B determinations of the *amount* of benefits. That conclusion does not mean that Congress intended that all judicial review of Part B determinations was prohibited. In view of the fact that Congress was delegating governmental powers to private parties, it is more reasonable to interpret the statute and its legislative history to mean that judicial review was to be available only to the extent of the courts' existing jurisdiction. Congress merely refused to specify in that section whether carriers' decisions were judicially reviewable. It thereby left the scope of such review to the courts' existing jurisdiction.

The Court of Claims read this legislative history as precluding judicial review of the *amount* of a particular benefit determination, not as precluding all judicial consideration of constitutional and statutory challenges to administrative actions simply because they have an affect on benefit determinations. P-14a. Such a reading was entirely consistent with the Court of Claims' rulings in *Goldstein* v. *United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U.S. 974 (1973), *Appalachian Regional Hospitals, Inc.* v. *United States*, *supra*, 576 F.2d at 861, and *Whitecliff, Inc.* v. *United States*, *supra*, 536 F.2d at 350-51.

The few sentences of legislative history cited by the United States fall far short of the clear and convincing evidence which would warrant its conclusion. In the absence of clear Congressional intent to the contrary, the Court of Claims was not barred from exercising its jurisdiction under 28 U.S.C. §1491. *See Johnson* v. *Robison*, *supra*, 415 U.S. at 373.

2). *42 U.S.C. §405(h) Does Not Preclude Court of Claims Jurisdiction Over Part B Determinations.*

The United States also argues that §205(h) of the Social Security Act, 42 U.S.C. §405(h), precludes all judicial review

of Part B determinations. Its reasoning, however, defies the plain meaning of that section.

Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.

That section is adopted by reference for the Medicare program in §1395ii.

The United States asserts that a decision by a carrier after a hearing conducted by the carrier is included within the statutory language "findings and decisions of the Secretary after a hearing . . . ." Giving the statutory language its plain meaning, however, Prudential is not the Secretary of Health and Human Services, and Section 405(h) simply does not apply.

Moreover, §1395ff distinguishes between determinations to be made by the Secretary and determinations to be made by others, and specifically refers to §405(g) (on judicial review) in relation only to those decisions required to be made by the Secretary. Section 1395u, which sets forth the procedures to be followed by carriers, in no way equates a decision by a carrier with a decision by the Secretary.

When Congress clearly distinguished in §1395ff and §1395u between proceedings to be conducted by the Secretary and proceedings to be conducted by a carrier, it is unlikely that it would blur that distinction in a parallel section by referring to a decision by a carrier as a decision by the Secretary.

Finally, the specific preclusion of actions in the district courts under section 41 of title 28 (28 U.S.C. §1331) to recover

on a claim under Part B of Medicare lends support to the continued exercise of Court of Claims jurisdiction as the appropriate forum for such cases.

II. The Decision Does Not Open the Floodgates of New Litigation or Announce Any Novel Proposition of Law.

The United States has asserted that the decision below would open the floodgates of litigation:

> "... The court's holding threatens to intrude the Court of Claims into the carrier's day-to-day administration of the Medicare program and to open that court to the very flood of small claims Congress sought to foreclose .... Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations .... The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing of 7191 cases. If only a fraction of the total number of dissapointed claimants were to seek review in the Court of Claims, the cited statistics indicate that there would be a considerable increase in that court's docket. This would, in turn, strain the scarce resources of the Secretary in defending against relatively minor monetary claims."

This contention is unrealistic. As an initial matter, the expense of litigating in the Court of Claims would screen out all but the most substantial disputes. The Government surely does not seriously contend that the Court of Claims docket is likely to become cluttered with $50 (or even $500) cases. In any event the Court of Claims, which ought to be most familiar with and concerned about the condition of its own docket,

did not share the Government's opinion that the Court might become overburdened or that the resources of the Secretary would be overtaxed by a sudden influx of cases into the Court of Claims.

Furthermore, the Court of Claims decision was not a departure from its prior holdings as to its jurisdiction. The Court of Claims merely followed well-established precedent, including *Goldstein* v. *United States, supra; Appalachian Regional Hospital, Inc.* v. *United States, supra; Whitecliff, Inc.* v. *United States, supra; see Overlook Nursing Home, Inc.* v. *United States*, 556 F.2d 500, 501-502 (Ct. Cl. 1977). The "floodgates" have been open for years, but the resultant "flood" of litigation has not materialized.

Indeed, Court of Claims jurisdiction over Part B issues has been widely recognized by other courts. Even the cases cited by the United States as denying federal District Court jurisdiction over Part B claims often state that the Court of Claims is one forum which does have such jurisdiction. For example, the United States cites *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980) to support the proposition that several decisions of Courts of Appeals "make clear that there is no right of judicial review of a carrier's benefit determinations under Part B." (Petition at 20). The Government apparently missed the following in that decision:

> Review is available in the Court of Claims if litigants can state a claim for actual or nominal damages .... This holds true for Part B as well as for Part A actions ....
>
> Appellants could have sought damages in their complaint, although they instead requested declaratory and injunctive relief. Judicial review of any substantial constitutional or statutory claim, therefore, is available in the Court of Claims under 28 U.S.C. § 1491.

611 F.2d 1005 n.6. *Accord, Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979) (also cited by the United States for the same proposition, Petition at 20); *Pushkin* v. *Califano*, 600 F.2d

486, 489-90 (5th Cir. 1979); see *United States* v. *Bellevue Hospital, Inc.*, 479 F.Supp. 780, 734 (D. Mass. 1979); *Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980). The Court of Claims' view of its jurisdiction in this case has been known to other courts, litigants and potential litigants for years.

The United States' argument that the court of Claims will be interjected into the day to day decisions of the carriers similarly lacks substantial merit. The United States asserted (P-16 n.8) that the court's limitation on its jurisdiction to consider only claims of statutory or constitutional violations was a mere fiction, since in the United States' view any claims of an improper benefit determination could be couched in terms of a statutory violation. Perhaps to reinforce that impression, the United States described the Court of Claims decision as one to review "the amount of benefits payable on the thousands of individual Part B claims assigned to [Erika]." (P-15).

There is no reason to presume that the Court of Claims will not respect a limitation on its jurisdiction which it itself has recognized, or that it is incapable of coping with efforts by litigants to change the substance of their claims by semantic legerdemain.

Moreover, the Court of Claims' actions in this case were consistent with a severely limited view of its jurisdiction, not with the United States' elastic description. The court in fact refused to conduct a review of the "thousands" of individual benefit determinations the United States claims were in issue. It remanded those determinations to Prudential for action consistent with both the statute and the carrier's discretion:

> On the present record, we cannot determine what Erika's customary charges were for its drugs and services for each of the calendar years involved. Nor do we attempt to prescribe the method by which the carrier should make that determination. Prudential might decide to average the different charges made during the calendar year, or to allocate the different charges on the basis

> of the time each was in effect, or to determine the mean charge, or to use some combination of these methods. Perhaps Prudential can devise a better method of calculation.

P-17a.

> The regulations give carriers substantial flexibility in setting reimbursement rates to look at more than just the customary and prevailing charges .... The determination whether to grant particular adjustments and permit departures from prevailing charges during the preceding calendar year, however, is within the discretion of the carrier. We cannot direct Prudential whether or how to exercise that discretion in a particular case.

P-21a.

The Court of Claims has neither opened the floodgates of litigation nor acted in a manner which would encourage attempts to define away the carefully delineated limits on its jurisdiction.

III. The United States' Position Would Unnecessarily Raise Substantial Constitutional Questions

The United States' interpretation would preclude all judicial scrutiny of statutory and constitutional[5] violations by

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[5] The Government seeks to avoid the constitutional issue inherent in its position by pointing out that the majority below found Erika's constitutional claims insubstantial. (The concurring opinion disagreed). However, the Government's jurisdictional arguments apply equally to both constitutional and statutory claims, and the Court of Claims decision applied with equal force to both.

When the Government argued that the decision below encroached on areas which Congress excluded from Court of Claims jurisdiction, the Government expanded on the Court of Claims' own limited expression of its jurisdiction. In contrast, in downplaying the constitutional questions implicit in the decision, the Government narrowed the Court of Claims' language. The issue before this Court is the actual Court of Claims holding, not a version which expands or contracts depending on the point sought to be made.

the carrier. The United States' position in substance is that it can delegate significant governmental functions to an insurance company and yet bar a person injured by the blatantly illegal acts of that company from obtaining any judicial relief. Even if the Medicare statute and the Tucker Act were ambiguous, they should be interpreted so as to avoid such a result.

In *Johnson* v. *Robison*, *supra*, for example, this Court stated that even a statute expressly prohibiting judicial review of a decision of an administrative agency should be construed if at all possible to avoid barring all judicial review of constitutional claims, 415 U.S. at 367. *A fortiori*, when there is no statute expressly prohibiting judicial review, legislative silence in face of a general statute granting jurisdiction to the Court of Claims should be construed to preserve that pre-existing jurisdiction.

The United States in effect asks this Court to decide whether Congress can circumvent the Constitution by delegating to private parties the authority to determine substantive rights and then allowing those parties to exercise that authority in violation of contracts, applicable statutes and even the Constitution without fear of judicial scrutiny. Because a principled alternative to deciding that constitutional question exists, however, that alternative should be chosen. *Johnson* v. *Robison*, *supra*; *see Whitecliff, Inc.* v. *United States*, supra, 536 F.2d at 350-51. The decision of the Court of Claims should be sustained, and certiorari should be denied.

Conclusion

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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APPENDIX

42 U.S.C. §405:

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. §1395u:

(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(A) determine compliance with the requirements of section 1395x(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1395x(k)(2) of this title) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contracts with carriers under subsection (a) of this section may be entered into without regard to section 5 of Title 41 or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y of this title, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment

is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirements in sub-paragraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this subchapter and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsis-

tent with the efficient and effective administration of the insurance program established by this part.

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1395h of this title.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 228a-2(b) of Title 45.

42 U.S.C. §1395ff:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

In the United States Court of Claims

No. 374-77

ERIKA, INC.,
PLAINTIFF
v.
THE UNITED STATES OF AMERICA,
DEFENDANT

MOTION FOR LEAVE TO FILE MEMORANDUM IN OPPOSITION TO MOTION FOR REHEARING

FILED JANUARY 26, 1981
ALLOWANCE ENTERED JANUARY 27, 1981

Plaintiff Erika, Inc. ("Erika") hereby moves to file herewith a Memorandum in Opposition to defendant's Motion for Rehearing. As reason for said motion, Erika states that contrary to the appearance of the motion itself and to the arguments submitted in support thereof, only this week, on January 19, it was informed that the United States in the said motion is seeking in effect a reversal of the decision of the Court of Claims. Erika also learned at this time directly from counsel for the Government that it would use the requested "clarification" against Erika itself to deny Erika the relief to which it is entitled under the Court of Claims' decision.

Prior to January 19, Erika believed that the defendant's motion was no more than a "clarification", with no applicability to the facts of Erika's case. It was not until January 19 that the defendant informed Erika of facts hitherto unknown to Erika—namely, that Prudential has lost, misplaced or disposed of data in the form given it by Erika. Defendant also informed Erika of its position that because of the missing data, it would rely on any grant of the "clarification" requested in the motion for rehearing to justify Prudential acting on remand to insist on the position it took prior to this Court's decision of October 22, 1980, notwithstanding that decision.

The grounds for opposition are more fully set forth in the accompanying memorandum, which plaintiff seeks herein leave to file.

By its Attorneys,

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In the United States Court of Claims

No. 374-77

ERIKA, INC.,
PLAINTIFF
v.
THE UNITED STATES OF AMERICA,
DEFENDANT

MEMORANDUM IN OPPOSITION TO MOTION FOR REHEARING

FILED JANUARY 27, 1981

Plaintiff Erika, Inc. ("Erika") opposes the Motion of defendant United States for rehearing on grounds that contrary to the appearance of the motion itself and to the arguments submitted in support thereof, Erika has just learned that the United States is seeking in the said motion to vitiate the decision of the Court of Claims and to deny Erika the relief to which it is entitled.

In the Motion for Rehearing the United States asserted that all it was seeking was a "clarification"—an order to the effect that the decision in this action did not invalidate a certain portion of the Medicare Carriers Manual. The relevant section of the Manual reads:

> "When a Carrier does not have adequate statistics on charges for suppliers of medical equipment, prosthetics, ambulance services, or for new services, the fees charged and the price lists in effect as of June 30 of that calendar year only should be used. *The intent is to use a price list which can reasonably be assumed not to exceed the median of the prices charged by the supplier for his items and services during the calendar year.* (Emphasis supplied.)

In this action it was Prudential's use of a single price list in setting the "customary charge" rather than actual statistical data as required by law that the Court found was improper. Since Erika did virtually all of its relevant billing to Prudential, and neither Prudential nor the United States had ever claimed that Erika had failed to submit any necessary statistics or other information, it was Erika's belief when the Government's motion was filed that under no circumstances would allowance of the motion effect the outcome of this case. Erika was well aware that Prudential had been supplied with data necessary to make the statutorily required calculations.

In the Government's motion filed on November 5, 1980, this was alluded to on page 4, where it was stated:

> "In the context of the court's assumption that Erika provided Prudential with complete data 'during the calendar year[s]' at issue, the meaning of the court's decision is clear. However, we believe that the Court did not intend to preclude carriers from relying on catalogue price lists when the carrier does not have adequate statistics on charges."

Since the Court's "assumption" was manifestly correct—Erika had provided the necessary data—the clear and intended implication of that language was that the requested "clarification" would not affect the outcome of Erika's case.

In its "substitute" motion filed November 14, 1980, the Government changed the above language to read "In the context of the Court's assumption that Prudential had adequate statistics on Erika's charges..." Still without suspicion of any subterfuge, Erika continued reasonably to assume that the Government was not seeking by the motion for "clarification" to reverse this Court's decision of October 22.

On January 19, 1981 at a meeting with defendant's counsel, representatives of the Social Security Administration and Prudential in an attempt to begin the remand process, counsel for Erika were informed that in the defendant's view if the "clarification" requested in the motion for rehearing were

granted, defendant would interpret it as allowing the conduct by Prudential which the Court condemned in its opinion because Prudential now believed it no longer had the statistical information admittedly submitted by Erika during the relevant years.

Erika therefore must strongly oppose the defendant's efforts to eviscerate the Court's decision.

It is unquestioned that Erika originally provided Prudential with sufficient information for Prudential to develop the statistics necessary to satisfy its obligations as stated in the Court's decision.

Prudential and the Government, however, now claim that due to the passage of time while this case was pending Prudential no longer has the necessary statistics, or that recreation of them would be prohibitively difficult and expensive. Prudential now asserts that under the quoted language of section 5010.1 of the Medicare Carriers Manual it should be allowed on remand to use the single date catalogue approach which it was sued for using in the first place. It seeks, therefore, to evade completely the decision of this Court since such an action would result in Erika receiving no relief whatsoever for the improper actions of Prudential.

Such an attempt is outrageous and should not be countenanced.

Any loss of data by Prudential during the time when Erika was pursuing its mandated administrative and judicial remedies was entirely due to Prudential, not to any action or fault on Erika's part. Prudential, however, now seeks to absolve itself of its own failure lawfully to use the data supplied it by Erika by invoking on its own negligence to preserve that data during the pendency of this action. Erika must not be penalized by Prudential's loss, destruction or alternation of its records.

The motion for rehearing is not seeking a "clarification", it is seeking a reversal. Erika therefore opposes it, and asks that the Court's decision and order for remand be left intact, and that excuses for defendant's asserted inability to comply with the Court's order not be sanctioned in advance.

Respectfully submitted,

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Office-Supreme Court, U.S.
FILED
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ALEXANDER L. STEVAS,

No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

REPLY BRIEF FOR THE UNITED STATES

WADE H. MCCREE, JR.
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Department of Justice
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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-1594

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

REPLY BRIEF FOR THE UNITED STATES

1.a. Respondent concedes (Br. in Opp. 8-10) that the pertinent provisions of Part B of the Medicare Act (42 U.S.C. 1395ff and 1395u) do not grant a right to judicial review of a carrier's determination of the amounts payable for particular Part B services. Respondent also concedes (Br. in Opp. 8-10) that there is not a single passage in the legislative history of Part B or amendments thereto that is indicative of a congressional intent to allow judicial review of Part B benefit determinations. Respondent contends, however, that such review must be available absent " 'clear and convincing' evidence of congressional intent * * * to restrict access to ju-

dicial review" (Br. in Opp. 7-8, quoting *Johnson* v. *Robison*, 415 U.S. 361, 373-374 (1974)). Because respondent does not find clear and convincing evidence here, it contends (Br. in Opp. 7-12) that Congress cannot be deemed to have "deprived" the Court of Claims of jurisdiction under 28 U.S.C. 1491 to entertain its suit seeking greater reimbursement on the thousands of individual claims assigned to respondent by users of its kidney dialysis supplies.

This argument must be rejected. The instant suit is not one for APA-type "judicial review" of an administrative determination, which courts often presume to be available absent an expression of congressional intent to the contrary. See, *e.g.*, *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 141 (1967). Rather, a suit in the Court of Claims under 28 U.S.C. 1491 must be one for "actual, presently due money *damages*" (*United States* v. *King*, 395 U.S. 1, 3 (1969); emphasis added). This Court has never suggested that a suit for money damages for an asserted statutory violation may be brought under the Tucker Act unless there is "clear and convincing" evidence of a congressional intent to foreclose such a suit. The rule is precisely the opposite: the congressional intent to allow a suit for money damages under the statute in question " 'must be unequivocally expressed' " (*United States* v. *Mitchell*, 445 U.S. 535, 538 (1980), and *United States* v. *Testan*, 424 U.S. 392, 399 (1976), both quoting *United States* v. *King*, *supra*, 395 U.S. at 4). Part B of the Medicare Act does not contain an "unequivocally expressed" waiver of sovereign immunity to a suit against the United States for money damages whenever a beneficiary (or his assignee) is dissatisfied with the amount of benefits the carrier

determines should be paid for particular Part B services.

b. Even if respondent were correct that a showing of "clear and convincing" evidence of congressional intent to foreclose judicial review is necessary to bar a damage action in the Court of Claims, that standard is plainly satisfied here. Respondent acknowledges that the 1965 Senate Report on the Medicare Act states that, under Part B, "carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits" and that the Act " 'does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A' " (Br. in Opp. 9, quoting S. Rep. No. 404 (Pt. I), 89th Cong., 1st Sess. 54-55 (1965)). But respondent contends (Br. in Opp. 10) that this sentence merely indicates that the Act is deliberately *silent* regarding the availability of judicial review of Part B benefit determinations and that judicial review under other provisions, such as 28 U.S.C. 1491, was therefore not intended to be precluded. Like the Court of Claims (see Pet. App. 13a), however, respondent conveniently fails to quote the concluding sentence of the very same passage in the Senate Report. That sentence states: *"It is intended that the remedies provided by these review procedures shall be exclusive"* (S. Rep. No. 404, *supra*, at 55; emphasis added). The Conference Report on the 1972 amendments reiterates that "there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B" (H.R. Conf. Rep. No. 92-1605, 92d Cong.,

2d Sess. 61 (1972).[1] Thus, Congress was anything but silent regarding the availability of judicial review of Part B claims; it unequivocally foreclosed such review.

2. Respondent argues, however, that 28 U.S.C. 1491 constitutes a general grant of jurisdiction over suits for money damages for a statutory violation wherever a federal statute " 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained' " (Br. in Opp. 6, quoting *United States* v. *Testan*, *supra*, 424 U.S. at 400, and *Eastport S.S. Corp.* v. *United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967)). Respondent contends that the Medicare Act should be so interpreted because, in its view, "Medicare legislation, fairly read, mandates appropriate payment to providers" (Br. in Opp. 6). Having thus found a general grant of jurisdiction under 28 U.S.C. 1491 in cases where a statute provides for payment of monetary benefits, respondent concludes (Br. in Opp. 7-12) that Congress did not intend to "carve[] out an exception" (*id.* at 7) to this general grant of jurisdiction applicable to Part B Medicare claims. This analysis is seriously flawed.

Contrary to respondent's contention, the issue here is not whether the Medicare Act withdraws or carves

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[1] In *McClure* v. *Schweiker*, No. C-79-0201 WHO (N.D. Cal. Apr. 9, 1981), the court held that the hearing procedures in Part B of the Medicare Act violate due process because they permit a carrier's hearing officer to make a final benefits determination without a right of appeal to the Secretary. The court ordered that beneficiaries be afforded a de novo hearing by an Administrative Law Judge in the Social Security Administration following any adverse decision by a carrier's hearing officer. The Solicitor General is currently considering whether to authorize a direct appeal of the decision to this Court under 28 U.S.C. 1252.

out an exception to a general grant of jurisdiction under the Tucker Act over claims for monetary payments. The jurisdictional grant in 28 U.S.C. 1491 applies only where the particular statute under which the claim arises itself creates a substantive right to sue the United States for damages. *United States* v. *Mitchell, supra*, 445 U.S. at 538. Thus, the issue in this case is whether Part B of the Medicare Act creates a substantive right to sue for money damages. Respondent has pointed to nothing in the text or legislative history of Part B to suggest that Congress intended to create a cause of action for money damages and thereby to trigger the jurisdiction of the Court of Claims under 28 U.S.C. 1491.

Surely the fact that Part B provides for a carrier to pay money in reimbursement for covered services does not in itself mean that Part B "can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained" (*United States* v. *Testan, supra*, 424 U.S. at 400) every time a carrier allegedly errs in making a benefit determination. When Congress barred administrative appeals to the Secretary and APA-type judicial review of adverse benefit determinations by the carriers,[2] it concluded that the relatively small

[2] Respondent contends (Br. in Opp. 11) that 42 U.S.C. 405(h), which bars review of findings of fact or decisions of the Secretary except as otherwise provided in the Act, does not apply to benefit determinations under Part B of the Medicare Act because they are made by carriers, not by the Secretary. But respondent cannot have it both ways. Respondent has, after all, sued the *United States* in the Court of Claims based on the carrier's determination, and it elsewhere contends (Br. in Opp. 7) that the United States is the real party in interest in Part B benefit disputes. Therefore, for purposes of the preclusion of judicial review stated in Section

amount of money involved in the typical Part B claim did not warrant the expense and burden of a review mechanism beyond the provision in 42 U.S.C. 1395u(b)(3)(C) for a fair hearing by the carrier where the amount in controversy exceeds $100. It would be entirely inconsistent with this statutory scheme to conclude that Congress had nonetheless rendered the United States potentially liable in money damages and for the expense and burden of litigation in the Court of Claims for every allegedly erroneous determination made by the expert carriers upon which it had chosen to rely.

3. Perhaps recognizing the weakness of its argument that the Court of Claims has Tucker Act jurisdiction of a claim for violation of the Medicare Act, respondent now argues (Br. in Opp. 5-6) that its claims also are contractual in nature and therefore are within the Court of Claims' Tucker Act jurisdiction over claims arising under a contract.[3] It is true that Prudential, the carrier in this case, had a contractual obligation under 42 U.S.C. 1395u to determine and pay the amounts provided for in the Act. But a beneficiary does not enter into a contract with

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405(h), a decision by the carrier must be deemed a decision by the Secretary. Moreover, the third sentence of Section 405(h) bars jurisdiction of any action "to recover on any claim arising under" the Act; it makes no reference to the Secretary and therefore plainly applies to Part B. In any event, as explained above (see pages 3-4, *supra*), the legislative history of the Medicare Act manifests a clear intent to bar all judicial review of carrier determinations under Part B.

[3] Contrary to respondent's assertion (Br. in Opp. 5), the Court of Claims did not hold that sums were due it as a matter of contractual as well as statutory right. The Court of Claims did not even address this issue.

the Secretary or the carrier. The beneficiary's right to receive the benefits determined by the carrier to be due derives directly from the Act. Thus, there is no independent contractual right in either the beneficiary or his assignee to receive Part B benefits that could furnish a basis for Tucker Act jurisdiction in the Court of Claims when Part B of the Medicare Act itself plainly does *not* furnish a basis for such jurisdiction.[4]

4. Respondent contends (Br. in Opp. 15-16) that substantial constitutional questions would be raised if the Medicare Act were construed to bar all judicial review of statutory or constitutional issues under Part B. But this Court has never suggested that it might be unconstitutional to preclude judicial review of *nonconstitutional* issues raised in administrative determinations. See *Califano* v. *Sanders*, 430 U.S. 99 (1977). Moreover, as we explain in the petition (at 19 n.11), the Court need not decide in this case whether there is jurisdiction in some court to consider constitutional challenges to the Medicare

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[4] Respondent cites (Br. in Opp. 6) only *Fox* v. *Harris*, 488 F. Supp. 488 (D. D.C. 1980), for the proposition that it has a contractual claim to benefits. In *Fox*, the plaintiff physician alleged that he and HEW had arrived at an agreement settling a Part B reimbursement dispute for a specified sum. The court stated (488 F. Supp. at 492) that the physician essentially had alleged that this particular settlement constituted a bilateral executory contract in which the government had agreed to pay the specified sum. The court then observed that a suit to enforce that particular settlement contract could be brought in the Court of Claims under 28 U.S.C. 1491. The Court in *Fox* did not hold that there is an independent contractual right generally to receive Part B Medicare benefits that can be asserted in the Court of Claims under 28 U.S.C. 1491. In the present case, unlike in *Fox*, respondent has not sought to recover on an alleged contract settling a reimbursement dispute.

Act, because the Court of Claims found respondent's constitutional claims to be insubstantial.

5. Respondent's attempts (Br. in Opp. 12-15) to minimize the potential practical consequences of the Court of Claims' decision in this case are unavailing. The Court of Claims has now held for the first time that it has jurisdiction over Part B Medicare claims. Contrary to petitioner's assertion (*id.* at 13), the result below was not foreordained by that court's earlier decisions finding Tucker Act jurisdiction in certain Medicare Part A cases, in view of the compelling legislative history demonstrating a congressional intent to bar judicial review specifically with respect to Part B claims. Plaintiffs who find their Part B claims barred in district court because of the decisions of the various courts of appeals cited in the certiorari petition (at 20-21) may now avoid these holdings simply by bringing suit in the Court of Claims.[6]

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[6] Respondent argues (Br. in Opp. 3-4) that Prudential committed two "substantial and obvious" errors in determining the amount of reimbursement that should be paid to respondent. But if Prudential's errors were so obvious, one wonders why respondent failed to identify one of them throughout the proceedings in the court below. As we pointed out in the petition (at 11 n.5), respondent did not argue below that Prudential had erred in using respondent's price list in effect on July 1 of each year in computing respondent's customary charges, rather than computing customary charges using actual charges in effect throughout the year as ordered by the Court of Claims (Pet. App. 16a-17a). Indeed, it is entirely possible that the use of a price list in effect at the midpoint of the year would yield approximately the same level of reimbursement as a weighted average of the prices charged throughout the year. If so, the difference in reimbursement would not be "substantial," as respondent suggests, despite the added administrative burden on Prudential.

The only other relief ordered by the Court of Claims was that Prudential not rely on a particular circular or certain

For the foregoing reasons and the additional reasons stated in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

WADE H. MCCREE, JR.
Solicitor General

MAY 1981

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statements by HEW officials in refusing to make a retroactive adjustment in reimbursement levels. Pet. App. 19a-21a. But the court did not order retroactive readjustment and it is not clear that respondent will receive any greater reimbursement as a result of the court's decision on this issue either.

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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1980

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether the Court of Claims has jurisdiction under 28 U.S.C. (& Supp. III) 1491 to review determinations by private insurance carriers of the amount of benefits payable under Part B of the Medicare Act, 42 U.S.C. (& Supp. III) 1395j *et seq.*

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In the Supreme Court of the United States

OCTOBER TERM, 1980

No. 80-1594

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE PETITIONER

OPINION BELOW

The opinion of the Court of Claims (Pet. App. 1a-28a) is reported at 634 F.2d 580. The decisions of the insurance carrier's hearing officer (Pet. App. 34a-88a) are unreported.

JURISDICTION

The opinion of the Court of Claims was issued on October 22, 1980. An order removing the case from the Court of Claims' docket (Pet. App. 29a) was entered on October 24, 1980. The Court of Claims' order on the government's motion for rehearing, clarifying certain aspects of the court's opinion (Pet. App. 30a-33a), was

entered on February 6, 1981. On January 12, 1981, the Chief Justice extended the time for filing a petition for a writ of certiorari to and including March 21, 1981. The petition was filed on March 20, 1981, and was granted on May 18, 1981. The jurisdiction of this Court rests on 28 U.S.C. 1255(1).

STATUTORY PROVISIONS INVOLVED

1. 28 U.S.C. (& Supp. III) 1491 (the Tucker Act) provides in pertinent part:

> The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. * * * To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just. * * *

2. Section 205(h) of the Social Security Act, incorporated into the Medicare Act through 42 U.S.C. 1395ii and codified at 42 U.S.C. (1970 ed.) 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any

person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.[*]

3. Section 1842 of the Social Security Act, 42 U.S.C. 1395u(b)(3)(C), states that each contract between the Secretary and a carrier must provide that the carrier

> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

4. Section 1869 of the Social Security Act, 42 U.S.C. 1395ff, provides in pertinent part:

> (a) Entitlement to and amount of benefits.
>
> The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) Appeal by individuals.
>
> (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or section 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or section 1819, or

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* In the 1976 edition of the United States Code, which has not been enacted into positive law, the third sentence of Section 205(h) is changed to refer to "sections 1331 and 1346" of Title 28 rather than "section 41 of title 28," as in the Social Security Act itself.

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

STATEMENT

Respondent brought this action in the United States Court of Claims seeking increased reimbursements for medical supplies that it sold to persons who were insured under Part B of the Health Insurance for the Aged and Disabled Act (Title XVIII of the Social Security Act, 42 U.S.C. (& Supp. III) 1395 *et seq.*), commonly known as the Medicare Act. Those customers of respondent had assigned thousands of their individual reimbursement claims to respondent for collection under the Medicare program. The only question presented in this Court is whether the Court of Claims had jurisdiction under 28 U.S.C. (& Supp. III) 1491 to entertain respondent's action.

1.*a.* The Medicare Program is divided into two parts. Part A of the Act (42 U.S.C. (& Supp. III) 1395c to 1395i-2) provides insurance for hospital and related post-hospital services. 42 U.S.C. (& Supp. III) 1395c and 1395d. Payments due under Part A are financed by the Federal Hospital Insurance Trust Fund, which consists of funds appropriated by Congress in an amount equal to the hospital insurance taxes paid by employees and employers under the Federal Insurance Contributions Act

(26 U.S.C. (& Supp. III) 3101(b) and 3111(b)) and taxes paid by self-employed individuals (26 U.S.C. (& Supp. III) 1401(b)). See 42 U.S.C. (& Supp. III) 1395i(a) and (h).

Payment for services covered by Part A of the Medicare program is made directly to the hospital or other provider of the services. 42 U.S.C. (& Supp. III) 1395g.[1] The Act directs the Secretary of Health and Human Services (HHS) to determine the amount of benefits payable to the provider for services rendered to a Part A beneficiary. 42 U.S.C. (& Supp. III) 1395f, 1395g and 1395x (v). However, the Secretary is authorized to enter into a contract with a fiscal intermediary (such as a Blue Cross Association) under which the intermediary will determine the amount of benefits payable to the provider of services and make those payments to the provider on behalf of the Secretary. 42 U.S.C. (& Supp. III) 1395h. If the individual beneficiary is dissatisfied with the intermediary's initial determination of the amount of benefits payable under Part A for particular services (including a determination that no benefits are payable), the Medicare Act grants the beneficiary the right to an administrative hearing conducted by the Secretary of HHS when the amount in controversy is $100 or more and a right to judicial review when the amount in controversy is $1,000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2).[2]

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[1] The term "provider of services" is defined generally to mean a hospital, skilled nursing facility, or home health agency. 42 U.S.C. 1395x(u).

[2] The beneficiary has a right to administrative and judicial review pursuant to 42 U.S.C. 1395ff(b) of the amount of benefits payable under Part A only when he may be personally liable to the provider for the amount disallowed under Medicare—such as when reimbursement is disallowed because of certain deductible or coinsurance features, limitations on days of hospitalization, or a determination by the intermediary that hospital care was not medically necessary. 42 C.F.R. 405.704(b), as amended, 46 Fed. Reg. 24564 (May 1, 1981); see 42 U.S.C. 1395cc(a)(1)(A); *Alabama Hospital Ass'n* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981), slip op. 12. However, if an intermediary determines that the "reasonable cost" of services is less than

b. Part B of the Medicare Act establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the reasonable charges for certain other medical and health services—primarily physicians' services and such items as medical supplies, x-rays and laboratory tests. See 42 U.S.C. (& Supp. III) 1395k, 1395*l*, 1395x(s), and 1395rr(b)(1). Benefits under Part B of the Medicare program are paid out of the Federal Supplementary Medical Insurance Trust Fund established in the Treasury. 42 U.S.C. 1395t(a) and (g). The Supplementary Trust Fund is supported by appropriations from the Treasury and by premiums paid by those persons who are 65 or older or disabled and who choose to enroll in the program. 42 U.S.C. (& Supp. III) 1395r(c), 1395s (f) and 1395w; see *Mathews* v. *Diaz*, 426 U.S. 67, 70 n.1 (1976).

The payment of Part B benefits is administered by private insurance carriers [3] pursuant to contracts entered into with the Secretary. 42 U.S.C. (& Supp. III) 1395u. When a claim is submitted for payment, the carrier determines whether the particular services are covered by Part B and, if they are, the amount payable for the services. The carrier also makes payments for the services on behalf of the Secretary. These payments generally are made either to the beneficiary directly or to the physician or other supplier of the Part B services to whom the beneficiary has assigned his claim. 42 U.S.C. 1395u(a)(1)

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the amount claimed by the provider, the provider cannot recover the excess amount from the beneficiary. 42 U.S.C. 1395cc(a)(1)(A); *Alabama Hospital Ass'n* v. *United States*, *supra*, slip op. 12. The provider has a right to administrative and judicial review of "reasonable cost" determinations when the aggregate amount in controversy for services rendered to all Medicare beneficiaries in a given accounting period is $10,000 or more. 42 U.S.C. 1395*oo*. The individual beneficiary has no right to administrative or judicial review of "reasonable cost" determinations, however, because he has no stake in the outcome. 42 C.F.R. 405.705(a), as amended, 45 Fed. Reg. 73932 (Nov. 7, 1980); see *Alabama Hospital Ass'n* v. *United States*, *supra*, slip op. 12.

[3] The term "carrier" is defined in 42 U.S.C. 1395u(f).

(A) and (B) and 1395u(b)(3)(B).[4] If the beneficiary is dissatisfied with the carrier's decision that Part B of the Medicare Act does not cover some or all of the services in question, or is dissatisfied with the carrier's determination of the amount payable for covered services, the Act requires that the carrier afford him the opportunity for a "fair hearing by the carrier" if the amount in controversy is $100 or more. 42 U.S.C. 1395u(b)(3)(C). If the claim has been assigned to the physician or other person who furnished the services, the assignee has the same right to a hearing by the carrier as the beneficiary. 42 C.F.R. 405.801. Unlike Part A of the Medicare Act, however, Part B contains no provision for an administrative hearing by the Secretary or judicial review of Part B claims that are denied by the carrier after the statutorily required "fair hearing" by the carrier.

2. Respondent is a major distributor of medical supplies used by patients undergoing kidney maintenance dialysis. Pet. App. 4a. For the years involved in this suit, respondent's customers included a large number of persons insured under Part B of the Medicare program.[5] Respondent accepted assignment of these persons' claims to reimbursement under Part B of the Medicare program

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[4] An exception to this rule is contained in 42 U.S.C. (& Supp. III) 1395k(a)(2) and 1395n, which provide that payments under Part B *must* be paid directly to a hospital, skilled nursing facility or similar entity on the basis of the reasonable cost of the services (rather than to the insured individual or his assignee) if the hospital or other entity furnished the services covered by Part B.

[5] By virtue of 42 U.S.C. (Supp. III) 426-1, all persons insured under the Social Security Act (and the spouses and dependent children of such insured persons) who are determined to have chronic renal disease and require hemodialysis or renal transplantation are eligible for Medicare benefits even though they have not attained age 65. This extension of coverage for persons requiring kidney maintenance dialysis or transplants first became effective for all services provided on or after July 1, 1973. See 42 U.S.C. 426(c), as added by Pub. L. No. 92-603, Section 299I, 86 Stat. 1463. Section 426(c) was revised and redesignated as Section 426-1 by Section 1 of Pub. L. No. 95-292, 92 Stat. 307.

for the supplies it furnished. See 42 U.S.C. 1395u(b)(3)(B)(ii).

The Prudential Insurance Company was designated by the Secretary as the insurance carrier for processing Part B claims in New Jersey, where respondent's business is based. Pet. App. 4a, 84a-85a. In this capacity, Prudential was responsible for determining the "reasonable charge" for supplies respondent sold to Part B beneficiaries. 42 U.S.C. 1395u(a)(1)(A) and (B). Prudential would then pay respondent 80% of the "reasonable charge" as reimbursement for the cost of those supplies. See 42 U.S.C. (& Supp. III) 1395*l*.

Under the statute, the prevailing charge made by all persons for similar services in the area during the preceding calendar year constitutes a ceiling on the "reasonable charge" that the carrier may set for services furnished by any one supplier. Specifically, for the years involved in this lawsuit, the "reasonable charge" for the particular services—80% of which would be reimbursed by the Medicare program—could not exceed the prevailing charge level that the carrier determined would cover 75% of all customary charges made for similar services in the same locality during the calendar year elapsing prior to the start of the 12-month period (beginning July 1 of each year) in which the bill was submitted or the request for payment was made. 42 U.S.C. (& Supp. III) 1395u(b)(3).[6] Because respondent's sales accounted

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[6] In December 1980, 42 U.S.C. (& Supp. III) 1395u(b)(3) was amended to provide that, effective July 1, 1981, the "reasonable charge" is to be calculated by reference to the prevailing charge in the locality during the calendar year preceding the 12-month period (beginning each July 1) in which the services were rendered, not the 12-month period in which the bill for the services was submitted to the carrier or the request for payment by the carrier was made. See Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, Section 946, 94 Stat. 2642-2643. The 1980 amendment has no bearing on the issues involved in this case. The pertinent portion of 42 U.S.C. 1395u(b)(3) previously had been amended in 1976 (Pub. L. No. 94-368, Section 3(b), 90 Stat. 997) to account for a

for almost all of the sales of the relevant supplies in New Jersey, where respondent's business was based, respondent's sales price for a particular product during the preceding calendar year established the prevailing charge level for that product and thereby became the "reasonable charge" on which respondent's 80% reimbursement was based. Pet. App. 4a-5a, 55a, 84a-85a.[7]

When respondent sold its dialysis supplies to persons who were insured under Part B of the Medicare program, it received assignments of their claims to reimbursement from Medicare. Respondent then submitted invoices to Prudential based on the prices in effect at the time it sold products to the beneficiaries from whom it had received assignments. Supp. Pet. ¶¶ 27, 43, 63.[8] However, because 42 U.S.C. (& Supp. III) 1395u(b)(3) requires that reimbursements be limited by the prevailing charge level in the *preceding* calendar year and because respondent's own sales established that level, Prudential reimbursed respondent on the basis of the prices contained in the catalogue issued by respondent on July 1 of the preceding calendar year. Thus, for invoices submitted between July 1, 1975 and June 30, 1976, Prudential reimbursed respondent on the basis of prices contained in respondent's July 1, 1974 catalogue.

Early in 1976, respondent requested that Prudential adjust the amounts of past and future reimbursements to reflect price increases that became effective after July 1, 1974. Pet. App. 6a, 35a-36a, 58a-59a, 78a; Supp. Pet.

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change in the federal government's fiscal year (see Pet. App. 4a n.4), but that amendment made no substantive change and likewise does not affect the issues involved in this case.

[7] Respondent issued an annual catalogue, effective July 1 of each year, that listed its prices for its products, whether or not they were sold to persons insured under Medicare. Respondent also issued catalogue supplements on occasion during the ensuing 12 months to reflect price changes. Pet. App. 5a.

[8] "Supp. Pet." refers to respondent's supplemental petition—*i.e.*, its complaint—in the Court of Claims.

¶¶ 30, 46 and 66.[9] Pursuant to Section 5010.2 of HHS's Part B Carriers Manual (Pet. App. 69a), which allows for adjustments in the amount of customary charges in "highly unusual situations where equity clearly indicates that the increases are warranted" (*ibid.*), Prudential granted a prospective adjustment in respondent's reimbursable "reasonable charge" for sales of the drug heparin made on or after May 26, 1976. Pet. App. 5a-6a; Supp. Pet. ¶ 47.[10] Prudential declined, however, to make a retroactive adjustment for heparin (Pet. App. 5a-6a).[11] For the other products involved in this case, moreover, Prudential declined to make either a retroactive *or* a prospective adjustment in the "reasonable charge" that was calculated on the basis of the July 1, 1974 catalogue price.[12] Prudential's initial determinations to limit adjustments in the manner described above were affirmed following a "fair hearing" by Prudential's hearing officer

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[9] In its complaint in the instant case, respondent alleged (Supp. Pet. ¶¶ 28, 44, 64) that it received periodic lump sum reimbursement payments from Prudential that totaled less than the amount claimed in the corresponding invoices, but that Prudential did not identify the reason for the disallowance. Respondent alleged that it subsequently discovered—apparently early in 1976 (Supp. Pet. ¶¶ 29, 45; see also *id.* at ¶ 65)—that Prudential was reimbursing it on the basis of the July 1, 1974 catalogue prices.

[10] This prospective adjustment was apparently occasioned by the shortage of meat from which heparin is manufactured and a resulting increase in the price of heparin by the manufacturers from which respondent purchased the drug for subsequent resale to dialysis patients. Pet. App. 5a-6a; Supp. Pet. ¶ 40.

[11] Prudential made a prospective adjustment, effective February 10, 1976, in the "reasonable charge" for another item for which the price allegedly had been misprinted in respondent's July 1, 1974 catalogue. Pet. App. 35a-36a; Supp. Pet. ¶¶ 24, 25 and 31. This aspect of the case, which was the subject of Count I of the Supplemental Petition in the Court of Claims, was subsequently settled by the parties and is not involved here. Pet. App. 1a n.1.

[12] Of course, for invoices submitted after July 1, 1976, reimbursement would have been made on the basis of respondent's July 1, 1975 catalogue, thereby resulting in increased reimbursement.

pursuant to 42 U.S.C. 1395u(b)(3)(C). See Pet. App. 6a, 34a-88a.

3.*a.* Following the decisions by Prudential's hearing officer, respondent filed the instant action in the Court of Claims, contending that Prudential's actions in denying increased reimbursements were inconsistent with the Medicare Act and violated the due process and equal protection guarantees of the Fifth Amendment.[13]

On cross-motions for summary judgment, the Court of Claims rejected the government's argument that the court lacked jurisdiction to decide respondent's reimbursement claims. The Court of Claims concluded (Pet. App. 6a-7a) that, on its face, respondent's contention—that Prudential's decision not to base reimbursement on respondent's current prices violated the Fifth Amendment and the Medicare Act—"states a claim" within the court's jurisdiction under the Tucker Act, 28 U.S.C. 1491. The court then rejected the government's contention that the text and legislative history of the Medicare Act nevertheless demonstrate Congress' intent not to subject a carrier's reimbursement determinations under Part B to judicial review.

The court acknowledged (Pet. App. 9a) that, in 42 U.S.C. 1395ff, Congress has expressly provided an individual beneficiary under Part A of the Medicare pro-

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[13] Respondent also contended (Supp. Pet. ¶¶ 37(c), 53(c), and 71(c)) that Prudential's failure to make the requested readjustments of reimbursements constituted a taking of respondent's property without just compensation, in violation of the Fifth Amendment. In making that assertion, respondent presumably intended to seek just compensation in the Court of Claims for the alleged taking, although the Request for Relief in the Supplemental Petition (at 35-37) does not refer to just compensation. The Court of Claims did not address respondent's taking claim, apparently finding it wholly without merit, and there is no occasion for this Court to consider that claim.

gram with a right to judicial review of the amount of benefits payable for particular Part A services, but has provided no such right for Part B beneficiaries or their assignees. Nevertheless, the court did not consider this omission to be sufficient evidence of Congress' intent to foreclose judicial review under Part B. In the court's view, 42 U.S.C. 1395ff establishes only the procedures to be utilized in obtaining judicial review of the particular determinations referred to in that section, and does not limit the availability of review to the determinations specifically mentioned therein. Thus, the court reasoned (Pet. App. 10a-11a), quoting *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977)):

> Where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.

The court concluded (Pet. App. 11a) that 28 U.S.C. 1491 is such a "general jurisdictional provision[]" for judicial review, and that judicial review of Medicare Part B determinations is therefore available in the Court of Claims notwithstanding Congress' failure to authorize judicial review of such determinations in the Medicare Act itself.[14]

The court likewise declined to attach significance to a passage in the Senate Report on the original Medicare Act stating that the Act "does not provide for judicial

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[14] The court also observed (Pet. App. 10a & n.6) that it had "refused" in *Whitecliff, Inc.* v. *United States*, *supra*, to "extend" the holding in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975)—that 42 U.S.C. 405(h) bars judicial review of benefit determinations except where expressly authorized in the Social Security Act itself—to the Medicare Act, even though 42 U.S.C. 405(h) is expressly made applicable to the Medicare Act. See 42 U.S.C. 1395ii.

review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A" (S. Rep. No. 404, 89th Cong., 1st Sess. 55 (1965)) and a similar statement made during floor consideration of the 1972 amendments to 42 U.S.C. 1395ff that "[t]he situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters" (118 Cong. Rec. 33992 (1972)). The court acknowledged that these statements reflected an intent to bar claims challenging the amount of reimbursement allowed in particular instances—"as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services" (Pet. App. 14a). But this purpose to bar a flood of small claims would not be thwarted, the court reasoned, "by permitting judicial review of contentions that particular benefit determinations violated constitutional or statutory provisions. For once a particular contention of that kind had been adjudicated, that issue would be settled, and there would be no occasion for further litigation of the point" (*id.* at 14a-15a). Accordingly, the court did not find the statements in the legislative history to constitute what it believed to be the requisite "clear and convincing" evidence of a congressional intent to preclude judicial review of Part B determinations (*id.* at 12a-13a, 14a).

b. On the merits, the Court of Claims rejected respondent's contention that the "reasonable charge" on which reimbursement is based under the Act must be the amount respondent actually billed for particular services, irrespective of the prevailing charge level during the preceding calendar year. The court found (Pet. App. 18a) that Congress clearly had provided otherwise in 42 U.S.C. 1395u(b)(3). The court also concluded (*id.* at 21a) that governing regulations permit carriers to make adjustments in reimbursements in special cir-

cumstances,[15] but that the determination whether to grant an adjustment is within the discretion of the carrier and the court could not "direct Prudential whether or how to exercise that discretion in a particular case" (*ibid.*).

Despite this expression of deference to a carrier's decision whether to grant an adjustment, the court concluded that Prudential had erred when it denied a retroactive adjustment of reimbursements for the drug heparin. The court determined (*id.* at 19a-20a) that Prudential's hearing officer should not have relied on an HHS directive providing that adjustments could be prospective only, because, in the court's view, that particular directive had become obsolete. The court also concluded that Prudential's hearing officer should not have relied on two letters from HHS officials that stated the same rule (see Pet. App. 46a-48a), finding that they "cannot be deemed to reflect the considered judgment of the Secretary" (Pet. App. 20a). The court therefore remanded this aspect of the case to Prudential to determine whether a retroactive adjustment should or could be made for sales of heparin on the basis of whatever standards and policies the Secretary has promulgated for retroactive adjustments. *Id.* at 20a-21a.

The Court of Claims also found that Prudential had erred in the manner in which it calculated the prevailing charge level for respondent's supplies in the preceding calendar year. The court concluded that Prudential had violated the requirement in 42 U.S.C. 1395u(b)(3) that the prevailing charge level be calculated on the basis of charges made in the locality for similar services "*during* the last preceding calendar year" (Pet. App. 15a-16a) (emphasis added), because Prudential looked only to the respondent's catalogue charges in effect on July 1, the *midpoint* of the preceding calendar year. In the court's view, Prudential was required to take into account prices charged throughout the year, including those in effect before July 1, which may have been lower

[15] But see 42 U.S.C. (& Supp. III) 1395u(b)(3) and 42 C.F.R. 405.504 (reasonable charge limited by prevailing charge level).

than the catalogue price, as well as any price increases that became effective later in the calendar year. The court therefore remanded the case to Prudential to redetermine the "reasonable charge" for all of respondent's supplies in accordance with its opinion (Pet. App. 18a).[16]

Finally, the court found "insubstantial" respondent's contention that Prudential's failure to reimburse it on the basis of its prices in effect when the services were rendered, rather than prevailing charge levels in the preceding calendar year, resulted in a denial of due process and equal protection (Pet. App. 22a). The court found it reasonable for Congress, "in order to control Medicare costs and to provide an orderly system for administering this vast and complex program, to base reimbursement upon charges made during the prior year" (Pet. App. 22a).

SUMMARY OF ARGUMENT

I.

The Court of Claims' assumption of jurisdiction under 28 U.S.C. 1491 to review determinations by insurance carriers of amounts payable in reimbursement for par-

[16] Respondent had not challenged the manner in which Prudential calculated the prevailing charge level on this ground. This failure perhaps can be explained by the existence of Section 5010.1 of the Carriers Manual (Pet. App. 89a-90a). That section expressly allows a carrier to utilize a price list in effect at the midpoint of the calendar year (albeit June 30, not the July 1 date used by Prudential here) in calculating a supplier's customary charges for the entire year if the carrier does not have adequate statistics on prices charged by the supplier at different times throughout the year. In any event, it is entirely possible that the use of a price list in effect at the *midpoint* of the year would yield approximately the same level of reimbursement as would a weighted average of the prices charged throughout the year. If so, the remand ordered by the Court of Claims would have little or no effect on the total amount of reimbursement respondent would receive. This Court need not consider the proper method of calculating prevailing charge levels, however, because only the issue of the Court of Claims' jurisdiction is presented for review here.

ticular services under Part B of the Medicare Act conflicts with Congress' intent, clearly expressed in the text and legislative history of the Medicare Act, to bar judicial review of these very determinations.

A. Congress chose to entrust the administration of the Part B Medicare program, which now entails review of more than 150 million claims annually, to private insurance carriers that are experienced in the determination and payment of such claims under private insurance policies. Accordingly, the carrier responsible for administering the Part B program in a particular area determines whether the services for which reimbursement is sought are covered by Part B and, if so, how much should be paid in reimbursement for those services.

The only provision in the Act for review of the carrier's initial reimbursement determination under Part B is contained in 42 U.S.C. 1395u(b)(3)(C), which requires the *carrier* to conduct a "fair hearing" on the claim if the amount in controversy is $100 or more. That section does not provide for an administrative hearing by the Secretary or judicial review of the carrier's decision after a hearing.

Nor is judicial review of Part B claims authorized by 42 U.S.C. 1395ff(b), which contains the sole provisions for administrative and judicial review at the request of a Medicare beneficiary. Section 1395ff(b) grants a right to an administrative hearing by the Secretary and subsequent judicial review in federal district court of an individual's eligibility to participate under the Part A and Part B programs, but that section furnishes a right to administrative and judicial review of the amount of benefits payable for particular services only under Part A. In these circumstances, accepted principles of statutory construction compel the conclusion that Congress' withholding of a right to judicial review of benefit amount determinations under Part B was deliberate and that such review is thereby foreclosed.

Moreover, 42 U.S.C. 1395ff(b)(2) grants a right to judicial review of benefit amount determinations under

Part A only if there is at least $1,000 in controversy. It would be anomalous for Congress so to limit judicial review of reimbursement determinations under the hospital insurance program in Part A, and yet to permit suits for the lesser amount involved in the typical Part B claim without regard to the amount in controversy, as respondent apparently argues. In addition, Congress has authorized judicial review of amount determinations under Part A only after the Secretary has conducted an administrative hearing on the claim. It is most unlikely that Congress would have granted a right to sue the *United States* to obtain judicial review of a *carrier's* reimbursement decision under Part B, which does not provide a similar opportunity for prior administrative review by the Secretary to determine whether the carrier erred.

The legislative history of the Medicare Act and the 1972 amendments thereto confirms that Congress intended to foreclose judicial review of Part B claims. The Senate Report on the original Act emphasizes that "carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits" under Part B and that the Act does not provide for judicial review of the amount of benefits under Part B because they would involve smaller amounts than claims under Part A. S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965). And the report makes clear that the provisions in the Medicare Act for review of determinations under Parts A and B—which, with respect to amount determinations under Part B, were limited to a hearing by the carrier—were intended to be "exclusive" (*ibid.*). Congress reiterated this intent when it amended 42 U.S.C. 1395ff(b) in 1972 to clarify the limitations on review embodied in the Act as originally passed. The Conference Report on the 1972 amendments states, for example, that "there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B." H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972).

The courts of appeals have acknowledged this clear congressional intent and uniformly have concluded that

judicial review of Part B reimbursement claims is barred in district court. The Court of Claims' decision in this case is inconsistent with these holdings and threatens to expose the Court of Claims to the very flood of small claims Congress sought to avoid.

B. The Court of Claims also is barred by Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), from reviewing a carrier's reimbursement determination under Part B of the Medicare Act. Section 205(h) is incorporated into the Medicare Act through 42 U.S.C. 1395ii. The second sentence of 42 U.S.C. 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided" (emphasis added). Because a carrier acts as the agent of the Secretary in considering Part B claims, no "tribunal"—in this case, the Court of Claims—may review the carrier's findings of fact or decision except as provided in the Medicare Act itself. Since nothing in the Medicare Act so provides, judicial review of Part B claims is foreclosed by 42 U.S.C. 405(h).

The Court of Claims has read 42 U.S.C. 405(h) to bar jurisdiction under 28 U.S.C. 1491 of claims arising under Title II of the Social Security Act, but it has refused to apply 42 U.S.C. 405(h) to bar claims under the Medicare Act. See *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 350-351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977), upon which the Court of Claims relied in the instant case. These holdings are inconsistent with 42 U.S.C. 1395ii, which provides that 42 U.S.C. 405(h) shall apply in Medicare cases "to the same extent" as in cases under Title II of the Social Security Act. Moreover, contrary to the apparent view of the Court of Claims in *Whitecliff* and the instant case, this Court did not suggest in *Johnson* v. *Robison*, 415 U.S. 361 (1974), that it might be unconstitutional for Congress to bar judicial review of administrative benefit determinations. The Court indicated that a constitutional question would arise only if judicial review of *constitutional* claims were barred, an issue not involved in this case.

II.

The holding of the Court of Claims that it had jurisdiction over this case under the Tucker Act, 28 U.S.C. 1491, is in direct conflict with established principles defining that court's jurisdiction under the Tucker Act. This Court has made clear that the Tucker Act merely confers jurisdiction on the Court of Claims whenever there is a substantive right, derived from some other source, to recover money damages in a suit against the United States. See *United States* v. *Mitchell*, 445 U.S. 535, 538 (1980); *United States* v. *Testan*, 424 U.S. 392, 398 (1976). The conferral of a right enforceable against the United States for money damages—and the consequent triggering of the Court of Claims' Tucker Act jurisdiction—"cannot be implied but must be unequivocally expressed." *United States* v. *King*, 395 U.S. 1, 4 (1969). The Medicare Act contains no such "unequivocally expressed" consent to suit against the United States on reimbursement claims under Part B. To the contrary, the text and legislative history of the Medicare Act manifest a clear congressional intent to bar such suits.

Contrary to respondent's contention, the mere fact that the Medicare Act provides for *private insurance carriers* to pay money in reimbursement for services they find to be covered by the Act and implementing regulations does not imply that Congress intended to render the *United States* potentially liable for damages, and for the expense and burden of litigation under the Tucker Act, every time a carrier allegedly errs in calculating the reimbursement due on one of the millions of Part B claims filed each year. Moreover, the third sentence of 42 U.S.C. 405(h), as incorporated in 42 U.S.C. 1395ii, expressly bars the district courts from exercising their Tucker Act jurisdiction (28 U.S.C. 1346(a)(2)) to entertain an action to recover on a claim under the Medicare Act. It is most unlikely that when Congress enacted the Medicare Act and expressly declined to waive the government's sovereign immunity to suit for money damages in the district court

under the Tucker Act, it nevertheless implicitly conferred a substantive right to recover money damages in a suit under the Tucker Act in the Court of Claims.

ARGUMENT

I. THE MEDICARE ACT BARS JUDICIAL REVIEW OF AN INSURANCE CARRIER'S DETERMINATION OF THE AMOUNT PAYABLE FOR PARTICULAR SERVICES UNDER PART B OF THE ACT

The Court of Claims' assumption of jurisdiction under 28 U.S.C. 1491 to review determinations by insurance carriers of amounts payable for particular services under Part B of the Medicare Act conflicts with Congress' clearly expressed intent to preclude judicial review of those very determinations. This congressional intent is evident in both the text and legislative history of the Medicare Act itself and in Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), which is incorporated into the Medicare Act. See 42 U.S.C. 1395ii.

A. The Text And Legislative History Of The Medicare Act Establish That Congress Intended To Foreclose Judicial Review Of Determinations Of Amounts Payable Under Part B

The text of the Medicare Act makes clear that Congress carefully considered the types of determinations under the Act that should be subject to administrative and judicial review and that Congress deliberately foreclosed such review of Part B benefit determinations.

As the Court of Claims recognized in this case (Pet. App. 19a), respondent's right to obtain reimbursement from Prudential for its sales of supplies to persons enrolled under Part B of the Medicare Act derives solely from those persons' assignment to respondent of their individual claims to reimbursement under the Act. See 42 U.S.C. 1395u(b)(3)(B)(ii). Accordingly, respondent

has only those rights of review of reimbursement claims that are available to the individual Part B enrollees from whom it has accepted assignments. See 42 C.F.R. 405.801(a); *Kechijian* v. *Califano*, 621 F.2d 1, 4 n. 4 (1st Cir. 1980); *Szekely* v. *Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975), cert. denied, 425 U.S. 960 (1976); cf. 42 U.S.C. 1395pp(d).[17]

The Part B Medicare program is vast and complex. We have been informed by HHS, for example, that more than 158 million individual reimbursement claims were submitted to carriers by or on behalf of persons enrolled under the program in 1980. See also *McClure* v. *Harris*, 503 F. Supp. 409, 416 (N.D. Cal. 1980) (124 million Part B claims filed in 1978). The Act assigns the responsibility for determining whether particular services are covered by Part B and the amount of reimbursement due for covered services in individual cases not to the Secretary, but to private insurance carriers with which the Secretary has entered into contracts for the administration of the Part B program in particular geographical areas. 42 U.S.C. (& Supp. III) 1395u. Congress

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[17] When Congress has thought it appropriate to grant an independent right of review to the person or entity that furnished services under the Medicare Act, it has expressly so provided. Thus, under 42 U.S.C. 1395*oo*, which was added in 1972 (Pub. L. No. 92-603, Section 243(a), 86 Stat. 1421), Congress has granted hospitals and other providers of services under Part A a separate right to administrative and judicial review of reimbursement determinations when the amount in controversy is $10,000 or more. See also 42 U.S.C. 1395ff(c) and 1395pp(d). Similarly, in 42 U.S.C. (Supp. III) 1395rr(b)(2)(D), Congress has granted facilities furnishing end stage renal disease services under Parts A and B a right of review pursuant to 42 U.S.C. 1395*oo*. Respondent does not qualify under this provision because it is not a facility for these purposes. 42 U.S.C. (Supp. III) 1395rr(b)(9). Congress has not granted an independent right of judicial review to a supplier of services under Part B. Accordingly, respondent's procedural rights must derive from those of persons enrolled under Part B who have assigned their claims to respondent.

chose to rely on insurance carriers to administer the Part B program because they are experienced in determining reasonable and customary charges for physicians' and other medical services in their respective localities by virtue of their insurance business in the private sector and therefore can process comparable Medicare reimbursement claims more efficiently than could a government agency. S. Rep. No. 404, 89th Cong., 1st Sess. 53-54 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 46 (1965); 42 C.F.R. 421.5(b).

1. ***The Text of the Medicare Act Shows that Congress Foreclosed Judicial Review of Part B Amount Determinations***

a. The Medicare Act prescribes a specific avenue for review of Part B reimbursement claims that initially have been denied by the carrier, in whole or in part. If the amount in controversy after the initial determination by the carrier is $100 or more, the Act requires that the individual Part B beneficiary be given "an opportunity for a fair hearing *by the carrier.*" 42 U.S.C. 1395u (b)(3)(C) (emphasis supplied).[18] If, as in the present case, the person enrolled under Part B has assigned his reimbursement claim to a physician or other person who furnished the services, the Secretary has provided by regulation that the carrier must furnish the same hear-

[18] As originally enacted in 1965, the Act required the carrier to provide an opportunity for a "fair hearing" without regard to the amount in controversy. See Social Security Amendments of 1965, Pub. L. No. 89-97, Section 102, 79 Stat. 310-311. In 1972, 42 U.S.C. 1395u(b)(3)(C) was amended to add the $100 amount-in-controversy requirement. See Social Security Amendments of 1972, Pub. L. No. 92-603, Section 262, 86 Stat. 1448.

HHS regulations require an additional level of review between the initial determination and the evidentiary hearing. See 42 C.F.R. 405.807-405.812. Under these regulations, the individual Part B beneficiary or his assignee has a right to a "review determination" by the carrier, which is made on the basis of the evidence submitted to the carrier at the time of the initial determination and any additional information the claimant chooses to submit. There is no amount-in-controversy requirement for this "review determination."

ing rights to the assignee. 42 C.F.R. 405.801(a).[19] However, 42 U.S.C. 1395u(b)(3)(C) contains no provision for an administrative hearing by the Secretary or judicial review of a claim that is denied after the "fair hearing by the carrier."[20] Thus, there is nothing in 42 U.S.C. 1395u(b)(3)(C)—the only section of the Medicare Act specifically dealing with review of reimbursement claims under Part B—to support a right to judicial review of those claims. Nor is there any support elsewhere in the Act for such a right to judicial review. Indeed, the structure of the Act affirmatively shows that Congress deliberately withheld judicial review of reimbursement claims under Part B.

b. The sole provisions for judicial review of Medicare determinations at the request of the Medicare beneficiary are contained in 42 U.S.C. 1395ff(b). See pages 3-4, *supra.* That subsection furnishes a right to an administrative hearing by the Secretary and subsequent judicial review

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[19] The Medicare Act itself does not require the carrier to provide an opportunity for an evidentiary hearing to a physician or other supplier of Part B services to whom the individual beneficiary has assigned his reimbursement claim. It requires only that the carrier provide a hearing to the "*individual* enrolled under [Part B]." 42 U.S.C. 1395u(b)(3)(C) (emphasis added). Thus, by virtue of the Secretary's regulation extending hearing rights to assignees of Part B claims as well, respondent has been accorded the opportunity for more extensive review of its reimbursement claims than was granted by Congress.

[20] In *McClure* v. *Harris*, 503 F. Supp. 409 (N.D. Cal. 1980), the district court held that the Part B hearing procedures violate the claimant's due process rights because they do not provide for an evidentiary hearing by the Secretary after a carrier has denied a Part B claim. The government has taken a direct appeal from the final judgment in *McClure*, which was entered on May 5, 1981. The jurisdictional statement in *McClure* was filed on July 31, 1981. On June 12, 1981, Justice Rehnquist granted a stay of the district court's judgment pending appeal (No. A-961, Oct. Term 1980).

to any person who is dissatisfied with the Secretary's determination as to (1) whether he meets the conditions prescribed in 42 U.S.C. (& Supp. III) 426 and 426a for entitlement to participate in the hospital insurance program under Part A; (2) whether he is eligible to enroll and has enrolled in the supplementary insurance program under Part B; or (3) the amount of benefits payable under Part A (including a determination that no benefits are payable under Part A in a particular case).[21] Because in 42 U.S.C. 1395ff(b) Congress expressly provided a right to judicial review under Part A with respect to both an individual's eligibility to participate in the Part A program *and* the amount of benefits payable in a particular case—but provided a right to judicial review under Part B only with respect to eligibility—accepted principles of statutory construction compel the conclusion that Congress' omission of a provision for judicial review of benefit amount determinations under Part B was deliberate and that such review was thereby intended to be foreclosed. See, *e.g.*, *Lehman* v. *Nakshian*, No. 80-242 (June 26, 1981), slip op. 6; see also *Monroe* v. *Standard Oil Co.*, No. 80-298 (June 17, 1981), slip op. 14; *Fedorenko* v. *United States*, No. 79-5602 (Jan. 21, 1981), slip op. 20-21.

c. Express limitations on the availability of judicial review of benefit amount determinations under Part A further support the conclusion that judicial review of benefit amount determinations is not available under

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[21] As explained above (see note 2, *supra*), an individual beneficiary does not have a right to an administrative hearing by HHS or judicial review with respect to the amount of benefits payable under Part A when the only issue is the "reasonable cost" of the services furnished by the hospital or other provider of Part A services. The provider does, however, have a right to administrative and judicial review of reasonable cost determinations when the amount in controversy is at least $10,000. 42 U.S.C. 1395*oo*.

Part B. Section 1395ff(b)(1) provides that, when there is a right to an administrative hearing by the Secretary and judicial review of entitlement and amount determinations, those proceedings are to be conducted in accordance with 42 U.S.C. 405(b) and (g), which govern hearings and judicial review of claims under Title II of the Social Security Act, 42 U.S.C. (& Supp. III) 401 *et seq.* (Old Age, Survivors, and Disability Insurance Benefits).[22] There is no amount-in-controversy requirement that must be satisfied under 42 U.S.C. 405(b) and (g) to obtain an administrative hearing by the Secretary and judicial review of claims under Title II of the Social Security Act. But 42 U.S.C. 1395ff(b)(2) provides that, with respect to the amount of benefits payable under Part A, an administrative hearing shall not be available if the amount in controversy is less than $100 and judicial review shall not be available if the amount in controversy is less than $1,000.[23] This demonstrates that even when Congress has chosen to authorize judicial review of benefit amount determinations under the Medicare Act, it deliberately has departed from established procedures under the Social

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[22] Section 405(b) directs the Secretary to grant a right to an administrative hearing to a person who makes a showing that his rights may be prejudiced by the Secretary's initial determination. Section 405(g) grants a right to judicial review of a final decision of the Secretary made after a hearing to which the person was a party, irrespective of the amount in controversy, in a civil action commenced within 60 days in federal district court.

[23] 42 U.S.C. 1395ff(b)(2) provides:

> Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection [which provides for review of benefit amount determinations under Part A], a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

Security Act by imposing additional limitations on the availability of review in order to keep relatively minor disputes out of the courts.

Given these carefully drawn restrictions on the availability of judicial review of claims for hospital and similar benefits under Part A, it would be illogical to infer that Congress nevertheless intended to permit judicial review of carrier reimbursement determinations under Part B without regard to the amount in controversy, as respondent apparently asserts. This result would be particularly anomalous in view of the fact that the typical Part B claim—a bill for a doctor's visit, laboratory tests, x-rays, or medical supplies—would be much less in amount than the typical Part A claim for reimbursement for the costs of hospital treatment. See S. Rep. No. 404, *supra*, at 54-55.

It also is significant that, while Congress *has* authorized judicial review in 42 U.S.C. 1395ff, it has done so only in cases in which there has been a prior administrative hearing conducted by HHS, as provided in 42 U.S.C. 405(b). See 42 U.S.C. 405(g); *Weinberger* v. *Salfi*, 422 U.S. 749, 763-767 (1975); *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976). Under Part B, however, there is no provision for administrative review by the Secretary of a carrier's determination of the amount of reimbursement due on a particular claim. It is most unlikely that Congress would have intended to permit an individual beneficiary or his assignee to *sue the United States* to recover on a claim that has been denied by the carrier, when Congress has not provided any prior opportunity for administrative review by expert agency officials in HHS to determine whether the claim should be paid without the need for litigation. See, *e.g.*, *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F. Supp. 532, 536 (C.D. Cal. 1968); *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 762. But cf. *McClure* v. *Harris*, *supra*, note 20.

Thus, the text and structure of the review provisions of the Medicare Act demonstrate that there is no right

to judicial review of a carrier's reimbursement determinations under Part B of the Act.[24]

2. *The Legislative History of the Medicare Act Confirms that Congress Foreclosed Judicial Review of Part B Amount Determinations*

a. The legislative history of the Medicare Act confirms that Congress intended to preclude judicial review of a carrier's determinations of the amount payable for particular services under Part B. The Senate Report on the 1965 Act unequivocally states that judicial review was not intended:

> The committee's bill provides for the Secretary to make determinations, under both the hospital insurance plan and the supplementary plan, as to whether individuals are entitled to hospital insurance benefits or supplementary medical insurance benefits and for hearings by the Secretary and judicial review where an individual is dissatisfied with the Secretary's determination. Hearings and judicial review are also provided for where an individual is dissatisfied with a determination as to the amount of benefits under the hospital insurance plan if the

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[24] A claimant cannot avoid this bar to judicial review by suing the carrier rather than the United States or an agency or officer thereof. As respondent concedes (Br. in Opp. 6), the United States would be the real party in interest in such a suit because it would pay any judgment. See also S. Rep. No. 404, *supra*, at 54; 42 C.F.R. 421.5(b); *Kuenstler* v. *Occidental Life Insurance Co.*, 292 F. Supp. 532, 535 (C.D. Cal. 1968). For this reason, the United States would defend the carrier in such litigation (28 U.S.C. 516; see *Kuenstler* v. *Occidental Life Insurance Co.*, *supra*), and thereby assume the burden of the litigation even though it was not named as a party. See also S. Rep. No. 404, *supra*, at 54 ("the Government would be expected to safeguard the interests of [the Secretary's] contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secertary"). Accordingly, the preclusion of judicial review of Part B determinations by carriers necessarily applies to suits against the carriers as well.

> amount in controversy is $1,000 or more. (*Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under part B where claims will probably be for substantially smaller amounts than under part A.*) Hospitals, extended care facilities, and home health agencies would be entitled to hearing and judicial review if they are dissatisfied with the Secretary's determination regarding their eligibility to participate in the program.[25] *It is intended that the remedies provided by these review procedures shall be exclusive.*

S. Rep. No. 404, *supra*, at 54-55 (emphasis added); see also H.R. Rep. No. 213, *supra*, at 47. As the last-quoted sentence makes clear, the procedure provided in 42 U.S.C. 1395u(b)(3)(C) for pursuing complaints about carrier reimbursement determinations under Part B—review by the carrier (rather than the Secretary) without subsequent judicial review—plainly was intended to be "exclusive."

b. Congress reiterated its intent to preclude judicial review of Part B claims when it revised 42 U.S.C. 1395ff (b) in 1972. The impetus for this revision was an apparent ambiguity in the wording of subsection (b) as originally enacted that had led some district courts to recognize a right to judicial review of an individual's "entitlement" to reimbursement for particular services under both Parts A and B of the Act, without regard to the amount in controversy. See, *e.g.*, *Ridgely* v. *Secretary of Dept. of Health, Education and Welfare*, 345 F. Supp. 983, 986-988 (D. Md. 1972), aff'd, 475 F.2d 1222 (4th Cir. 1973); *Bohlen* v. *Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), aff'd, 483 F.2d 918 (3d Cir. 1973);

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[25] See 42 U.S.C. 1395ff(c).

Cardno v. *Finch*, 311 F. Supp. 251 (E.D. La. 1970).[26] In response to these decisions, Congress amended 42 U.S.C. 1395ff(b) to read as it now does. This amendment makes clear that judicial review is available on questions of "entitlement" only with respect to the threshold determinations whether an individual is *eligible to participate* in the Part A program and whether he is *eligible to enroll and has enrolled* under Part B. 42 U.S.C. 1395ff(b)(1)(A) and (B). Whether a person who is participating under Part A or enrolled under Part B is "entitled" to be reimbursed for particular services is now a question of the *amount* of benefits that are payable,[27] for which judicial review is available under 42 U.S.C. 1395ff(b)(1)(C) *only under Part A*, and only if $1,000 or more is in controversy.

Senator Bennett, who introduced the amendment to 42 U.S.C. 1395ff on the Senate floor, explained the pur-

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[26] As originally enacted, 42 U.S.C. (1970 ed.) 1395ff(b) read:

> Any individual dissatisfied with any determination under subsection (a) of this section as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

The decisions cited in the text construed the word "entitlement" in this section broadly to refer to whether particular services were covered by Part A or B (and thereby "entitled" an individual to any reimbursement in the particular case), not merely to whether the individual was eligible to participate in the Part A or Part B program at all, as Congress had intended. See also *Alabama Hospital Ass'n.* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981), slip op. 11 (Part A dispute arising before the 1972 amendment to 42 U.S.C. 1395ff(b)).

[27] This is made clear by 42 U.S.C. 1395ff(b)(1)(C), which provides for a right to administrative and judicial review of a determination as to "the amount of benefits under Part A (*including a determination where such amount is determined to be zero*)" (emphasis added).

pose of the amendment—*i.e.*, to keep minor claims, such as those under Part B, out of the courts (118 Cong. Rec. 33992 (1972); emphasis added):

> [T]he purpose of the amendment is to make sure existing law, which gives the right of a person to go to court on the question of eligibility to receive welfare, *is not interpreted to mean he can take the question of the Federal claim to court. If he did we would never have an end to it.* This is to reconfirm the original intention of the law that the courts can determine only eligibility.
>
> *The situations in which medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters. The law refers to "entitlement" as being an issue subject to court review and the word was intended to mean eligibility to any benefits of medicare but not to decisions on a claim for payment for a given service.*
>
> If judicial review is made available where any claim is denied, as some court decisions have held, the resources of the Federal court system would be unduly taxed and little real value would be derived by the enrollees. The proposed amendment would merely clarify the original intent of the law and prevent the overloading of the courts with trivial matters because the intent is considered unclear.

The Conference Committee accepted the Senate provision proposed by Senator Bennett, explaining:

> The Senate amendment added a new section to the House bill which would make clear that *there is no authorization for an appeal to the Secretary or for judicial review on matters solely involving amounts of benefits under Part B*, and that insofar as Part A amounts are concerned, appeal is authorized only if the amount in controversy is $100 or more and judicial review only if the amount in controversy is $1,000 or more.
>
> The House recedes.

H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added).

c. In view of this unequivocal legislative history, there can be no doubt that Congress intended to foreclose judicial review of a carrier's determination of the amount of benefits due under Part B.[28] Indeed, the courts of appeals are in agreement on this point with respect to the jurisdiction of the district courts. See *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3-4; *Bussey* v. *Harris*, 611 F.2d 1001, 1005 n. 5 (5th Cir. 1980); *Drennan* v. *Harris*, 606 F.2d 846, 850 n. 1 (9th Cir. 1979); cf. *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283, 289 (8th Cir.), cert. denied, 429 U.S. 977 (1976); *Bohlen*, *supra*, 483 F.2d at 919 & n. 1, 922; *Ridgely*, *supra*, 475 F.2d at 1224.[29] These courts have recognized that judicial review of Part B benefit determinations would "involve the courts in the complex and detailed task of 'ascertaining the appropriate medical charges for technical services—based

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[28] The Third Circuit, on appeal of one of the cases that had prompted the 1972 amendment to 42 U.S.C. 1395ff(b), recognized that there is no right to judicial review of a carrier's benefit determinations under Part B in cases covered by the amended section. *Bohlen*, *supra*, 483 F.2d at 919 & n.1, 922; see also *Ridgely*, *supra*, 475 F.2d at 1224; *Rubin* v. *Weinberger*, 524 F.2d 497, 499 n.2 (7th Cir. 1975); *Simoncelli* v. *Weinberger*, 418 F. Supp. 87, 89-90 n.4 (E.D. Pa. 1976); *Hamilton* v. *Blue Cross of North Dakota*, 375 F. Supp. 1049 (D.N.D. 1974).

[29] See also *Monmouth Medical Center* v. *Harris*, 494 F. Supp. 590, 596 (D.N.J. 1980); *Greenspan* v. *Blue Cross Blue Shield of Greater New York*, 432 F. Supp. 1339 (E.D.N.Y. 1977). Several district courts have assumed jurisdiction under 28 U.S.C. 1331 to hear challenges to the Secretary's actions under Part B. *Schupak* v. *Califano*, 454 F. Supp. 105, 112-113 (E.D.N.Y. 1978); *Mid Atlantic Nephrology Center, Ltd.* v. *Califano*, 433 F. Supp. 23, 31-33 (D. Md. 1977). These decisions are incorrect, in our view, because jurisdiction was barred by 42 U.S.C. 405(h). See pages 33-38, *infra*. But even in these cases, the plaintiffs did not seek review of individual reimbursement decisions by a carrier, as respondent did in the instant case.

on facts which vary from community to community'" and that "'the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.'" *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3, quoting *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 289. No reason appears why the preclusion of judicial review of Part B claims does not apply equally to the Court of Claims or why that court is any better suited than the district courts to review complex determinations by expert insurance carriers of the "reasonable charge" that may be paid for medical and health services covered by Part B.

If affirmed by this Court, the Court of Claims' holding that Congress' clearly expressed intent to preclude judicial review of Part B claims may be ignored would intrude that court (and perhaps the district courts as well) into the carriers' day-to-day administration of the Medicare program and open the judicial system to the very flood of small claims Congress sought to foreclose. Compare *Johnson* v. *Robison*, 415 U.S. 361, 370-373 (1974).

As noted above (see page 21, *supra*), more than 150 million reimbursement claims are now filed under Part B each year. Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations. See 42 C.F.R. 405.807 *et seq.*; note 18, *supra*. The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing in 7191 cases. If only a fraction of the total number of disappointed claimants were to seek review in the Court of Claims or the district courts, the cited statistics demonstrate that there would be a significant increase in the workload of these courts. This would, in turn, strain the scarce resources of the Secretary and the Attorney

General in defending against relatively minor monetary claims. Such consequences should not be imposed on the judicial and executive branches in the face of Congress' clearly expressed purpose to avoid them.

B. Section 205(h) Of The Social Security Act, As Incorporated In The Medicare Act, Also Bars Judicial Review Of Respondent's Claim

1. Section 205(h) of the Social Security Act, as codified at 42 U.S.C. (1970 ed.) 405(h), provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of title 28 to recover on any claim arising under this subchapter.[30]

Section 405(h) has been incorporated into the Medicare Act "to the same extent as [it is] applicable with respect to" Title II of the Social Security Act. 42 U.S.C. 1395ii.

The insurance carrier with which the Secretary has entered into a contract for the administration of the Part B program in a particular geographical area acts on behalf of the Secretary in performing its obligations under the contract, including the holding of the "fair hearing" required by 42 U.S.C. 1395u(b)(3)(C). See S. Rep. No. 404, *supra*, at 54; 42 C.F.R. 421.5(b). Consequently, by virtue of the first sentence of 42 U.S.C. 405(h), the carrier's findings and decision after a hearing on a Part B claim are "binding upon all individuals

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[30] In the 1976 edition of the United States Code, which has not been enacted into positive law, the third sentence of Section 205(h) is changed to refer to "sections 1331 or 1346" or Title 28, rather than "section 41 of title 28" as in the Social Security Act itself.

who were parties to such hearing" in the same manner as if the hearing had been conducted by the Secretary. See also 42 C.F.R. 405.835. And because for purposes of the carrier hearing a supplier of Part B services such as respondent stands in the shoes of the individual Part B beneficiaries from whom it has accepted assignments of reimbursement claims,[31] Prudential's findings and decision with respect to the reimbursement claims tendered by respondent were binding upon respondent. See also 42 C.F.R. 405.835.

In addition, the second sentence of 42 U.S.C. 405(h) provides that "[n]o findings of fact or decision of the Secretary shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided" (emphasis added). Because a carrier acts as the agent of the Secretary, no "tribunal"—in this case, the Court of Claims—may review the carrier's findings of fact or decision except as otherwise provided in the Medicare Act itself. Since nothing in the Medicare Act provides for judicial review in these circumstances, review is barred by the literal terms of the second sentence of 42 U.S.C. 405(h).[32] *Califano* v. *Sanders*, 430 U.S. 99,

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[31] See 42 C.F.R. 405.801, 405.802(b), 405.805, 405.808 and 405.822.

[32] Under this Court's decision in *Weinberger* v. *Salfi*, *supra*, the third sentence of 42 U.S.C. 405(h) likewise would bar an action in district court under 28 U.S.C. 1331 or the Tucker Act (28 U.S.C. 1346(a)(2)) on a claim arising under Part B of the Medicare Act. See *Kechijian* v. *Califano*, *supra*, 621 F.2d at 3-4; *Bussey* v. *Harris*, *supra*, 611 F.2d at 1005-1006; *Drennan* v. *Harris*, *supra*, 606 F.2d at 850; *Trinity Memorial Hospital* v. *Associated Hospital Service, Inc.*, 570 F.2d 660, 666-667 (7th Cir. 1977); *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 287-289. Because the third sentence of 42 U.S.C. 405(h), by its terms, only bars jurisdiction in the district courts, it does not literally apply to actions brought in the Court of Claims. Nevertheless, the policy clearly expressed in the third sentence of Section 405(h) that judicial review of claims under the Social Security Act (including its Medicare title) is barred except when Congress expressly has provided to the contrary applies equally to actions in the Court of

110-111 (1977) (Stewart, J., concurring in the judgment); cf. *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 757. In short, Congress' incorporation of 42 U.S.C. 405(h) into the Medicare Act independently compels the conclusion that is evident from the text and legislative history of 42 U.S.C. 1395u(b)(3)(C) and 1395ff(b), discussed above—that Congress expressly has foreclosed judicial review of reimbursement decisions by insurance carriers under Part B.

2. The Court of Claims acknowledged in the instant case (Pet. App. 10a n.6) that, in *Weinberger* v. *Salfi*, *supra*, this Court construed Section 405(h) to bar review of the Secretary's determinations under Title II of the Social Security Act except as provided in Title II itself (*i.e.*, pursuant to 42 U.S.C. 405(g)). But the Court of Claims disposed of the government's contention in this case that Section 405(h) bars an action to recover on a claim under Part B of the Medicare Act

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Claims. Thus, the third sentence of Section 405(h) reinforces the plain meaning of the second sentence, which *does* expressly bar review of the Secretary's decision by *any* "tribunal", including the Court of Claims. Indeed, by the cumulation of prohibitions in 42 U.S.C. 405(h), Congress clearly has manifested its intent to foreclose all review of administrative findings and conclusions in this context. The kinds of routine findings and conclusions involved in this case—concerning the amount of reimbursement due under Part B of the Medicare Program—are at the core of Congress' manifest concern in 42 U.S.C. 405(h).

Some courts of appeals have taken the position that, notwithstanding 42 U.S.C. 405(h), the district courts have jurisdiction under 28 U.S.C. 1331 of constitutional challenges to the Medicare Act. *Chelsea Community Hospital* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980); *St. Louis University* v. *Blue Cross Hospital Service*, *supra*, 537 F.2d at 291-293; see also *Kechijian* v. *Califano*, *supra*, 621 F.2d at 4. These decisions have no relevance here, because the Court of Claims found respondent's constitutional claims to be "insubstantial" (Pet. App. 22a). Moreover, respondent would not have a cause of action in the Court of Claims under 28 U.S.C. (Supp. III) 1491 to recover money damages even if it had alleged a substantial constitutional claim. See note 39, *infra*.

simply by asserting that it previously had "refused to extend *Salfi*" to Medicare cases. Pet. App. 10a n. 6, citing *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 350-351 (Ct. Cl. 1976), cert. denied, 430 U.S. 969 (1977).

In *Whitecliff*,[33] the Court of Claims did not cite anything in the language or legislative history of Section 405(h) or the Medicare Act that would justify its refusal to enforce the preclusion of judicial review in Medicare cases. Nor did the court suggest that Section 405(h) does not apply to actions in the Court of Claims. Indeed, that court has relied upon Section 405(h) in other cases to support a holding that it does not have jurisdiction of actions brought to recover disability benefits under Title II of the Social Security Act. See *Hickman* v. *United States*, No. 510-80C (Feb. 27, 1981), pet. for cert. pending, No. 80-6756; *Burton* v. *United States*, 205 Ct. Cl. 846 (1974).

Instead, *Whitecliff* reasoned that, while the effect of the reading of Section 405(h) in *Salfi* was only to channel judicial review of claims under Title II of the Social Security Act through 42 U.S.C. 405(g), the effect of giving Section 405(h) the same reading in Medicare cases would be to bar judicial review in broad categories of cases for which judicial review is not otherwise available under the Medicare Act. Such a result, the court believed, would "undermine the normal presumption in favor of judicial review" (536 F.2d at 350), and might be of doubtful constitutional validity (*ibid.*). Thus, because it concluded that judicial review should be available in some court, the Court of Claims refused to apply 42 U.S.C. 405(h) to Medicare cases.

The Court of Claims' decision in *Whitecliff*, which was followed in the instant case, is clearly incorrect. First, 42 U.S.C. 1395ii expressly provides that Section 405(h) and the other provisions incorporated into the Medicare

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[33] *Whitecliff* was an action brought in the Court of Claims by a provider of services under Part A of the Medicare Act.

Act shall apply with respect to the Medicare Act "*to the same extent* as they are applicable with respect to Title II [of the Social Security Act]" (emphasis added). Accordingly, there simply is no basis for giving Section 405(h) a less expansive reading in the instant case than has been given it in *Salfi* and other cases arising under Title II. Moreover, whatever may be the "presumption" in favor of judicial review of administrative decisions in other contexts, the language of 42 U.S.C. 405(h), 1395u(b)(3)(C), and 1395ff, and the legislative history of the Medicare Act, plainly reverse any such presumption in Medicare cases: judicial review is *not* available unless Congress expressly has so provided.

In addition, and contrary to the Court of Claims' suggestion, this Court has not indicated that it may be unconstitutional for Congress to withhold a right to judicial review of administrative determinations made pursuant to an Act of Congress (see, *e.g.*, *Califano* v. *Sanders*, *supra*), except perhaps in the case of constitutional claims. See *Johnson* v. *Robison*, 415 U.S. 361, 366-367 (1974). The statute at issue in *Johnson* v. *Robison*, 38 U.S.C. 211(a), bars judicial review of routine benefit determinations by the Veterans' Administration, yet the Court did not intimate that this broad preclusion might be unconstitutional. The Court indicated only that there would be a constitutional question raised if a judicial challenge to the *constitutionality* of the veterans' benefit statutes had been barred by 38 U.S.C. 211(a). 415 U.S. at 366-367; see *Califano* v. *Sanders*, *supra*, 430 U.S. at 109.[34] Indeed, notwithstanding its reliance on *Johnson* v. *Robison* in *Whitecliff* (536 F.2d at 350 n.7) and in the instant case (Pet. App. 11a-12a), the Court of Claims consistently has interpreted 38 U.S.C. 211(a) to bar jurisdiction in that court of actions to recover veterans' benefits, even though the result necessarily was to pre-

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[34] The Court construed 38 U.S.C. 211(a) not to bar such challenges. 415 U.S. at 366-374.

clude all judicial review. See *Baker* v. *United States*, No. 145-80C (Oct. 17, 1980); *Jennings* v. *United States*, 214 Ct. Cl. 789, 790 (1977); *Martin* v. *United States*, 197 Ct. Cl. 1062 (1972); *Jump* v. *United States*, 164 Ct. Cl. 453, 454 (1964); *Brown* v. *United States*, 150 Ct. Cl. 836, 840 (1960). The Court of Claims has offered no reason why Section 405(h) should not be given the same expansive reading here, as required by its literal terms.

Moreover, the same considerations, identified by the Court in *Johnson* v. *Robison*, which led Congress to preclude judicial review of veterans' benefit determinations —the need to avoid the expense and burden of litigation and to ensure the adequacy and uniformity of complex benefit determinations by expert administrative personnel (415 U.S. at 368-373)—apply equally to determinations by insurance carriers under Part B of the Medicare Act. Thus, it is not surprising that the courts of appeals, in contrast to the Court of Claims, uniformly have applied 42 U.S.C. 405(h) in Medicare cases "to the same extent" as it applies under Title II of the Social Security Act. 42 U.S.C. 1395ii. See the cases cited in note 32, *supra*.

II. THE DECISION BELOW IS INCONSISTENT WITH THE DECISIONS OF THIS COURT CONCERNING THE JURISDICTION OF THE COURT OF CLAIMS UNDER THE TUCKER ACT

The holding of the Court of Claims that it had jurisdiction over this case under the Tucker Act, 28 U.S.C. 1491, is in direct conflict with established principles regarding that court's jurisdiction under the Tucker Act.

A. On two recent occasions, this Court has made clear that the Tucker Act " 'does not create any substantive right enforceable against the United States for money damages,' " but rather "merely 'confers jurisdiction upon [the Court of Claims] whenever the substantive right exists.' " *United States* v. *Mitchell*, 445 U.S. 535, 538

(1980), quoting *United States* v. *Testan*, 424 U.S. 392, 398 (1976); see also *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976). It is therefore necessary to look outside of the Tucker Act itself—in this case, to the Medicare Act—to find a waiver of sovereign immunity with respect to a particular claim, which would in turn trigger the jurisdictional grant in 28 U.S.C. 1491. Accordingly, the Court of Claims had jurisdiction of the instant case under 28 U.S.C. 1491 only if the Medicare Act "confer[s] a substantive right to recover money damages from the United States" (*United States* v. *Testan*, *supra*, 424 U.S. at 398) whenever a private insurance carrier may have erred in determining the amount of reimbursement to be paid on a particular claim under Part B.

The conferral of a substantive right to recover money damages in a suit against the United States—and the consequent conferral of jurisdiction on the Court of Claims under 28 U.S.C. 1491 to entertain the suit—"'cannot be implied but must be unequivocally expressed.'" *United States* v. *Mitchell*, *supra*, 445 U.S. at 538, and *United States* v. *Testan*, *supra*, 424 U.S. at 399, both quoting *United States* v. *King*, 395 U.S. 1, 4 (1969); see also *Lehman* v. *Nakshian*, *supra*, slip op. 4. The Medicare Act contains no "unequivocally expressed" consent to suit against the United States on individual reimbursement claims under Part B. To the contrary, the text and legislative history of the Medicare Act and Section 205(h) of the Social Security Act, discussed in point I, *supra*, make clear that Congress deliberately foreclosed judicial review of all Part B claims. Congress' preclusion of judicial review in 1965 and 1972 would be of no effect if a claimant could obtain such review simply by filing a suit for money damages in the Court of Claims. This Court has recognized that the Court of Claims has no jurisdiction under the Tucker Act when the statute involved manifests a congressional intent to bar judicial review of an administrative determination of benefits (*United States* v. *Babcock*, 250 U.S. 328, 331

(1919)), and the Court of Claims has adhered to this principle in other contexts. See *Shull* v. *United States*, No. 16-78 (Ct. Cl. July 10, 1981), slip op. 8-12 (considering the preclusion of review in 31 U.S.C. 242); *Hickman* v. *United States*, *supra*, and *Burton* v. *United States*, *supra* (42 U.S.C. 405(h)); *Baker* v. *United States*, and other cases cited at page 38, *supra* (38 U.S.C. 211(a)); *Fountain* v. *United States*, 427 F.2d 759 (1970), cert. denied, 404 U.S. 839 (1971) (42 U.S.C. (1964 ed. Supp. IV) 1465(e)). There is no basis for the Court of Claims' failure to apply that principle in the instant case.

B. Respondent argues, however, that 28 U.S.C. 1491 constitutes a general grant of jurisdiction over suits for money damages for a statutory violation wherever a federal statute " 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained' " (Br. in Opp. 6, quoting *United States* v. *Testan*, *supra*, 424 U.S. at 400, and *Eastport Steamship Corp.* v. *United States*, 372 F.2d 1002, 1009 (Ct. Cl. 1967)). Respondent contends that the Medicare Act should be so interpreted because, in its view, "Medicare legislation, fairly read, mandates appropriate payment to providers" (Br. in Opp. 6). Having thus hypothesized a *general* grant of jurisdiction under 28 U.S.C. 1491 over all cases arising under statutes that provide for the payment of monetary benefits, respondent concludes (Br. in Opp. 7-12) that Congress did not intend to "carve[] out an exception" (*id.* at 7) to this general grant of jurisdiction applicable to Part B claims. The Court of Claims followed a similar approach, viewing the question presented as whether the Medicare Act "repealed by implication a portion of [its] jurisdiction under the Tucker Act" (Pet. App. 9a). This analysis is seriously flawed.

Contrary to the views of respondent and the Court of Claims, the question presented by this case is not whether the Medicare Act has withdrawn or "repealed" jurisdiction that could be said to have been conferred on the

Court of Claims by the Tucker Act itself. The Tucker Act is only a *conditional* grant of jurisdiction: it confers jurisdiction on the Court of Claims only when some *other* statute affirmatively confers a substantive right to recover money damages in a suit against the United States. Accordingly, the question presented is whether the Medicare Act affirmatively creates a right to sue the United States and thereby triggers the *grant* of jurisdiction to the Court of Claims, not whether the Medicare Act *withdraws* or *repeals* a grant of jurisdiction that has been independently conferred.[35] As we have explained above, the Medicare Act plainly does not confer a substantive right to recover money damages in a suit against the United States.

Surely, the mere fact that Part B of the Medicare Act provides for *private insurance carriers* to pay money in

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[35] Thus, respondent and the Court of Claims err in their reliance on the statement that the Tucker Act confers jurisdiction over cases arising under a federal statute whenever that statute "'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained'" as a result of a violation (*United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport Steamship Corp.* v. *United States*, *supra*, 372 F.2d at 1009). The quoted language is not a rule for construing the Tucker Act. Rather, it is a tool of statutory construction that can be utilized in determining whether some *other* federal statute (here, the Medicare Act) confers a substantive right to sue the United States to recover money damages and thereby triggers the conditional grant of jurisdiction in the Tucker Act. Whether the Medicare Act affirmatively confers such a right requires an analysis of the Medicare Act as a whole, including the nature of the benefits conferred, the number and complexity of reimbursement determinations, the provisions for administration of the Part B program by insurance carriers without Secretarial review, and the provisions precluding judicial review of carrier determinations. The fact that the Medicare Act provides for the payment of monetary benefits is only one element of the broader inquiry whether the United States has waived its immunity to *suit* for money damages. That Congress has chosen to distribute monetary benefits administratively—or, here, through private insurance carriers—does not mean that Congress intended to expose the United States to *suit* on a claim for such benefits. Compare *Johnson* v. *Robison*, *supra*.

reimbursement for services they find to be covered by the Act and implementing regulations does not, contrary to respondent's contention (Br. in Opp. 6), mean that Part B can "fairly be interpreted as mandating compensation by the *Federal Government* for the damage sustained" (*United States* v. *Testan*, *supra*, 424 U.S. at 400; emphasis added) every time a carrier errs in calculating the reimbursement due on one of the millions of Part B claims filed each year.[36] When Congress barred administrative appeals to the Secretary and APA-type judicial review of adverse reimbursement determinations by the carriers, it concluded that the relatively small amount of money involved in the typical Part B claim did not warrant the expense and burden of a review mechanism beyond the provision in 42 U.S.C. 1395u(b)(3)(C) for a fair hearing by the carrier. It would be entirely inconsistent with this statutory scheme and with Congress' decision to entrust the administration of the Part B program to expert insurance carriers in the private sector for Congress nonetheless to have rendered the United States potentially liable in money damages, and for the expense and burden of litigation under the Tucker Act, for every allegedly erroneous determination made by a carrier.

C. Moreover, in the third sentence of 42 U.S.C. 405(h), which is incorporated into the Medicare Act through 42 U.S.C. 1395ii, Congress has expressly foreclosed the *district courts* from exercising their Tucker Act jurisdiction (28 U.S.C. 1346(a)(2)) to entertain actions against the United States to recover on any claim arising under the Medicare Act.[37] It is most unlikely that when

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[36] As explained above (see page 26, *supra*), it is most unlikely that Congress would have created a substantive right to recover money damages in a suit against the United States without providing for prior administrative review by the Secretary of the particular Part B claim.

[37] The third sentence of Section 405(h) provides that "[n]o action against the United States * * * shall be brought under sec-

Congress enacted the Medicare Act and expressly declined to waive the government's sovereign immunity to suit for money damages in district court under the Tucker Act, it nevertheless implicitly created a substantive right to recover money damages in a suit under the Tucker Act in the Court of Claims.[38]

Finally, the manner in which the Court of Claims will exercise its jurisdiction in these cases demonstrates the error of its jurisdictional holding. The Court of Claims stated (Pet. App. 14a) that it would not actually review the amount of reimbursement found to be due in a particular case. Rather, if the court finds a statutory error, as it did in this case, it will remand to the carrier to redetermine the reimbursement under what the court finds to be the appropriate standards. Thus, the court will not award a judgment of "actual, presently due money damages" (*United States* v. *King*, *supra*, 395 U.S. at 3), but will, instead, grant a form of equitable or declaratory relief by way of remand. This underscores

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tion 41 of title 28 to recover on any claim arising under this subchapter." Prior to the 1948 revision of title 28 of the United States Code, Section 41 of that title contained all of the title's general grants of jurisdiction to United States district courts. *Weinberger* v. *Salfi*, *supra*, 422 U.S. at 756 n.3. Paragraph 20 of Section 41 contained the grant of jurisdiction under the Tucker Act to the District Courts, concurrent with that of the Court of Claims, where the amount in controversy does not exceed $10,000. See 28 U.S.C. (1940 ed.) 41(20). The version of 42 U.S.C. 405(h) in the 1976 edition of the United States Code expressly refers to 28 U.S.C. 1346, which now contains the grant of Tucker Act jurisdiction to the district courts.

[38] When Congress has provided for judicial review under the Medicare Act, it has mandated that the procedures in 42 U.S.C. 405(g) be followed (see 42 U.S.C. 1395ff(b)), including the requirement that a petition for review be filed within 60 days of the Secretary's decision. In contrast, a claimant presumably would have six years to bring an action in the Court of Claims under the Tucker Act. See 28 U.S.C. 2401. Congress could not have intended such a result. See *Califano* v. *Sanders*, *supra*, 430 U.S. at 108.

the conclusion that reimbursement determinations under Part B of the Medicare Act cannot properly be reviewed in a suit for money damages in the Court of Claims under the Tucker Act. *United States* v. *Testan, supra*, 424 U.S. at 404-405; *United States* v. *King, supra*; see Rogers, *A Way Out of the Social Security Jurisdiction Tangle*, 21 Ariz. L. Rev. 689, 719-721 (1979).[39]

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[39] In addition to alleging that Prudential's reimbursement determinations violated the Medicare Act, respondent also contended that Prudential's failure to reimburse it on the basis of its current prices, unaffected by the prevailing charge level during the preceding calendar year, violated the Due Process Clause of the Fifth Amendment. The language in 28 U.S.C. 1491 providing that the Court of Claims "shall have jurisdiction to render judgment upon any claim against the United States founded * * * upon the Constitution" has been construed to confer jurisdiction only where the particular constitutional provision relied upon can be read to mandate the payment of money damages by the United States for a violation. Although the Just Compensation Clause of the Fifth Amendment may be so read (*United States* v. *Testan, supra*, 424 U.S. at 401), the Due Process Clause of the Fifth Amendment may not. See *United States* v. *Hopkins, supra*, 427 U.S. at 130. The Court of Claims likewise has held that it does not have jurisdiction over claims founded upon the Due Process Clause where, as here, there is no jurisdiction over claims founded upon the particular statute involved. See *Alabama Hospital Ass'n.* v. *United States, supra*, slip op. 5; *Gordon* v. *United States*, No. 310-79T (May 6, 1981), slip op. 2 n.2; *Carruth* v. *United States*, 627 F.2d 1068, 1081 (Ct. Cl. 1980). The Court of Claims therefore was without jurisdiction to entertain respondent's constitutional claim as well. There is no occasion in this case to consider whether the district courts might have jurisdiction over constitutional challenges to the Medicare Act, particularly in view of the fact that the Court of Claims found respondent's constitutional arguments to be insubstantial in any event.

CONCLUSION

The judgment of the Court of Claims should be reversed.

Respectfully submitted.

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In the Supreme Court of the United States

OCTOBER TERM, 1981

UNITED STATES OF AMERICA,
PETITIONER,

v.

ERIKA, INC.,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE RESPONDENT

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I

Questions Presented

1. Does the Court of Claims have jurisdiction under 28 U.S.C. § 1491 (1976 & Supp. III 1979) to adjudicate a claim that a Medicare intermediary has violated the Constitution or federal statutes in determining benefits payable under Part B of the Medicare Act, 42 U.S.C. § 1395j *et seq.* (1976 & Supp. III 1979)?

2. When Congress enacted 42 U.S.C. § 1395ff (1976), did it, by implication, partially repeal the Tucker Act, 28 U.S.C. § 1491, to eliminate Court of Claims jurisdiction over constitutional and statutory challenges to Part B Medicare determinations?

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In the Supreme Court of the United States

OCTOBER TERM, 1981

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UNITED STATES OF AMERICA,
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v.

ERIKA, INC.,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF FOR THE RESPONDENT

Statutes Involved

28 U.S.C. § 1491 (1976 & Supp. III 1979):

> The Court of Claims shall have jurisdiction to render judgment upon any claims against the United States founded either upon the Constitution, or any act of Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases

> not sounding in tort .... To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just ....

42 U.S.C. §§ 405(h), 1395u and 1395ff (1976 & Supp. III 1979) are reproduced at Appendix A-1 *et seq.*

Statement of the Case

The only issue before this Court is whether the Court of Claims had jurisdiction to adjudicate the claim of Erika, Inc.[1] ("Erika") for payments due to Erika from the Government under Part B of the Health Insurance for the Aged and Disabled Act, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395j *et seq.* (1976 & Supp. III 1979), commonly known as the Medicare Act. The Medicare Act was passed in 1965 as part of the Social Security Act of that year.

The Medicare Program is divided into two parts. Part A is an insurance program covering hospital and related post-hospitalization services, 42 U.S.C. §§ 1395c to 1395i-2 (1976 & Supp. III 1979). Part A is financed by the Federal Hospital Insurance Trust Fund, with funds appropriated by Congress

[1] Erika, Inc. is a wholly owned subsidiary of Bio-Medical Applications Management Company, Inc., which in turn is a wholly owned subsidiary of National Medical Care, Inc., a public corporation. Bio-Medical Applications Management Company, Inc. has approximately 200 other subsidiaries, most of which are wholly owned by it and none of which are less than 95 percent owned by it.

in an amount equal to certain taxes paid by employees, employers and self-employed persons. *See* 42 U.S.C. § 1395i(a) & (h) (1976 & Supp. III 1979), 26 U.S.C. §§ 1401(b), 3101(b) & 3111(b) (Supp. III 1979).

Part B is a voluntary supplemental insurance program, 42 U.S.C. §§ 1395j - 1395w (1976 & Supp. III 1979), generally relating to non-hospital medical care providers such as physicians. *Id.* §§ 1395l, 1395x(s). Persons enrolling in Part B do so voluntarily and pay a monthly premium to participate. *Id.* § 1395r. Their premiums, together with contributions by the United States, are paid into the Federal Supplementary Medical Insurance Trust Fund. *Id.* § 1395t. This trust fund is separate from that established under Part A.

Part B benefits are administered by private insurance carriers, pursuant to contracts entered into between the carriers and the Secretary of Health and Human Services.[2] 42 U.S.C. § 1395u (1976 & Supp. III 1979). The contracts with the carriers require them to determine, using statutory guidelines, reasonable charges for covered medical services provided to the beneficiaries. Eighty per cent of these charges are paid to the beneficiary by the carrier on behalf of the Secretary, or to the provider of the services if the provider has obtained a valid assignment from the beneficiary. *Id.* §§ 1395l & 1395u(b)(3)(B). The statute requires that the contracts between the carriers and the Secretary must provide for "a fair hearing by the carrier" if a request for payment is denied or a dispute arises over the amount of payment for a service, and if the amount in controversy is $100 or more. *Id.* § 1395u(b)(3)(C). There is no express provision in the statute for review by the Secretary or any governmental administrative agency of the carrier's decision as to reasonable charges or as to nonpayment for a particular service.

Coverage under both Parts A and B was extended effective July 1, 1973 to any covered person, regardless of age, who re-

[2] Or by his predecessor, the Secretary of Health, Education and Welfare.

quires kidney maintenance dialysis. 42 U.S.C. § 426-1 (Supp. III 1979) & former § 426(e)(1976). Erika is a New Jersey based major distributor of kidney dialysis equipment and supplies throughout the United States. *Erika, Inc.* v. *United States*, 634 F.2d 580, 583 (Ct. Cl. 1980) (Pet. App. 4a); Pet. App. 84a-85a.[3] Since 1974, as an assignee of its customers/patients, Erika has billed its carrier, The Prudential Insurance Company of America ("Prudential"), for sales of covered products to patients eligible for coverage under Part B. *id.* Under 42 U.S.C. § 1395u(b)(3) (1976 & Supp. III 1979), Prudential's contract with the Secretary required Prudential to determine the "reasonable charges" for those products and to pay Erika 80 per cent of these "reasonable charges."

In administering the Part B payments to Erika, Prudential was required, pursuant to its contract with the Secretary and 42 U.S.C. § 1395u (1976 & Supp. III 1979), to limit its determination of "reasonable charges" in general to be no higher than the "customary charges" by Erika and the "prevailing charges" in the locality. Because Erika's Part B billing to Prudential represented the overwhelming majority of the billings submitted to Prudential for such services, Prudential considered Erika's customary charges to be the prevailing charges in the locality. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 584 (Pet. App. 4a-5a); Pet. App. 55a, 84a-85a.

Since Erika submitted its invoices to Prudential directly, Prudential had available to it all of Erika's actual charges for Part B supplies and services and hence could have derived exact statistical data on Erika's customary charges as well as "prevailing" charges. However, instead of using statistical data derived from actual charges, Prudential took Erika's catalogue prices as of July 1 in any given year and determined that those prices were both the customary charges and the prevailing charge for that calendar year. *See* U.S. Br. at 9.

[3] References to documents reproduced in the Appendix to the Petition for Certiorari are denoted "Pet. App."; in the Appendix to the Brief in Opposition "Opp. App."; in the Appendix hereto "App." References to the Supplemental Petition in the Court of Claims are denoted "Supp. Pet." and to the Brief for the Petitioner "U.S. Br."

It then used those catalogue prices instead of actual statistical data as the "prevailing charge" limit on reasonable charges payable to Erika for the fiscal year commencing on the following July 1. As an example, Prudential used Erika's July 1, 1974 catalogue prices alone as the "reasonable charges" for the year from July 1, 1975 through June 30, 1976. *Id.* Prudential thereby ignored both available later supplements to the catalogues and the prices actually billed by Erika. Prudential never used any available statistical data to determine actual customary or prevailing charges.

Erika, upon discovering the manner in which Prudential had been determining "reasonable charges", objected to the mechanical application of Erika's July 1 catalogue prices. Early in 1976, Erika requested that Prudential adjust the amounts of past and future reimbursements to reflect Erika's actual prices. 634 F.2d at 584 (Pet. App. 6a); Pet. App. 35a-36a, 58a-59a, 78a; Supp. Pet. ¶¶ 30, 46, 66. In particular, Erika claimed, first, that its July 1, 1974 catalogue contained a substantial printing error for one price, which was corrected in a supplement to the catalogue issued shortly thereafter. Supp. Pet. Count I. Prudential nonetheless had used the misprinted price as the limit on reimbursement until February, 1976.[4] Second, with respect to a particular product, heparin, which at the time was subject to rapidly rising prices due to a worldwide shortage of beef, from which it is made, Erika claimed that it was entitled to recognition of those price increases as they took place. Prudential made an adjustment for the price of heparin but only effective prospectively as of months, or years, after the increases took place. Supp. Pet. Count II. Third, Erika objected to the fact that while the July 1 prices for many products were often increased after the cata-

[4] Prudential's refusal to correct its prior use of the 1974 printing error to determine reasonable charges was the subject of Count I of Erika's Petition in the Court of Claims. That Count was settled and it is not here in issue. See U.S. Br. at 10 n.11.

logue was issued, Prudential ignored all catalogue supplements effecting those adjustments. It also ignored actual sales data in favor of using the single July 1 catalogue prices. Supp. Pet. Count III. Moreover, Erika claimed that Prudential's use of Erika's price as automatically establishing both the "customary" and "prevailing" charge was anomalous due to an accident of geography, logically circular, unreasonable and contrary to the Medicare statute. Erika therefore challenged Prudential's practices as being, *inter alia*, arbitrary and in violation of the Medicare statute and the Constitution.

Prudential declined to change its practices and to make the requested adjustments and changes. Retroactive adjustment was denied altogether on the basis of certain directives which Prudential believed prohibited it from granting *any* retroactive adjustment. Erika then requested a "fair hearing" from Prudential's hearing officer. *See* 634 F.2d at 584 (Pet. App. 6a); Pet. App. 34a-88a. After receiving adverse decisions from Prudential's hearing officer, no further administrative appeal being available, Erika in July 1977 brought the subject action against the United States in the Court of Claims.

Erika's petition sought a money judgment in the Court of Claims to correct Prudential's refusal to pay Erika its reasonable charges computed pursuant to the Medicare statute and the Constitution. Erika claimed, and the Court of Claims, sitting *en banc* at the request of the United States, unanimously held, on cross motions for summary judgment on the issue of liability:

(1) that Prudential's method of setting the level of "reasonable charges" for Erika was directly in violation of the Medicare statute, 634 F.2d at 588-89 (Pet. App. 15a-19a); and

(2) that with respect to the determination that Erika was entitled to prospective but not retroactive relief on the charges for heparin, the directive prohibiting retroactive relief on which Prudential had specifically relied was acknowledged to be obsolete and not to cover the years in question. 634 F.2d at 590-91 (Pet. App. 6a-7a).[5]

[5] The above are the only claims as to which the Court of Claims granted relief. Erika asserted other claims, including claims that Prudential's

Prudential had thus engaged in practices directly violative of federal law (and its contract with the Government) in its treatment of Erika's Part B claims. Prudential's statutory (and contractual) violation was so substantial and so obvious that it warranted unanimous summary judgment on liability by the full bench of the Court of Claims. In his concurring opinion Judge Nichols was moved to describe Prudential's actions as "virtual spoliation." Pet. App. 26a.[6]

With respect to the jurisdictional issue, the Court of Claims unanimously held that it had jurisdiction to adjudicate Erika's claims of statutory and constitutional violations in the determination of Part B benefits. Consistent with the procedural posture of the case (the issue of damages had not been addressed in the cross motions for summary judgment on liability), the Court of Claims remanded to Prudential for determination of the amount of damages. In doing so, it was careful

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actions violated the "Just Compensation" Clause of the Fifth Amendment to the Constitution. The United States describes that constitutional claim as a claim under the Due Process Clause, U.S. Br. at 44 n.39, *but see*, U.S. Br. at 11 n.13, and asserts that while the Court of Claims would have jurisdiction over a "Just Compensation" claim, it did not have jurisdiction over a "Due Process" claim. *Id.* Erika in fact pleaded both Just Compensation and Due Process Clause claims. Supp. Pet. ¶ 71(c) ("Those actions . . . deprive the Plaintiff of property without due process of law, and take Plaintiff's property without just compensation, in violation of the Fifth Amendment to the United States Constitution.") While the Court of Claims found the "due process" and "equal protection" claims insubstantial. 634 F.2d at 591 (Pet. App. 22a), the majority appears not to have addressed the "just compensation" claim. *Id.* Judge Nichols in his concurring opinion found the Fifth Amendment taking claim, however, to be at least colorable, and was troubled by the short shrift the majority gave it. 634 F.2d at 593-94 (Pet. App. 27a-28a).

[6] During the pendency of a motion for rehearing filed by the Government, which related to a portion of the Medicare Carriers Manual not directly in issue in this case, Erika's counsel was informed by Prudential that if the motion for rehearing were allowed Prudential would use that determination to avoid correcting the statutory violation found by the Court of Claims. (Opp. App. A-12—A-13). Erika brought this to the attention of the Court of Claims which inserted a final paragraph into its Order on rehearing to prevent Prudential from doing so. Pet. App. 32a-33a. The Carrier's attempted action in this regard was consistent with the type of behavior to which Judge Nichols referred.

not to encroach on areas left to Prudential's discretion and expertise in setting reasonable charge levels. 634 F.2d at 589, 591 (Pet. App. 17a-18a, 21a).

On March 20, 1981, the United States filed a Petition for Writ of Certiorari for review of the decision of the Court of Claims, but limited solely to the issue of the Court of Claims' jurisdiction. The petition was granted on May 18, 1981. No petition or cross-petition was filed with respect to the merits of the Court of Claims' decision.

Summary of Argument

The Court of Claims' jurisdiction over Medicare Part B claims arises under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979).

The Tucker Act constitutes a general grant of jurisdiction in the Court of Claims over non-tort claims for money judgments against the United States. Jurisdiction in the Court of Claims over Medicare Part B claims therefore exists under the Tucker Act if there is a substantive right to money damages against the United States under Part B and if Congress has not acted partially to repeal the Tucker Act or to withdraw the substantive right.

A substantive right to money damages against the United States under Part B arises both as a matter of contract and because the Medicare Statute, fairly read, mandates such a substantive right to recover damages. With respect to contract rights, Part B is a voluntary insurance program into which beneficiaries pay premiums. Such a program creates an implied-in-fact contract pursuant to which the beneficiaries are entitled to judicial enforcement of their rights against the United States. Moreover, Prudential, as agent for the Secretary, entered into an implied-in-fact contract with Erika requiring payment to Erika, in amounts to be determined consistent with the statute, for goods and services provided by Erika and accepted by the Part B beneficiaries and Prudential.

Finally, even if there were no implied-in-fact contracts, Erika could enforce, as a third party beneficiary, the Secretary's express contract with Prudential. By entering into such contracts, the United States has waived its sovereign immunity and created a substantive right to recover damages in the Court of Claims.

Even in the absence of contractual rights, Part B of the Medicare statute creates a system of medical insurance which mandates a right of the premium paying beneficiaries to enforce judicially their rights to receive payment in accordance with the statute. Erika, as assignee, stands in the shoes of those beneficiaries.

Nothing Congress has done has withdrawn that substantive right of action under Part B or repealed the Court of Claims' Tucker Act jurisdiction over those substantive claims. In particular, contrary to the argument of the United States, in enacting 42 U.S.C. §§ 1395ff & 405(h) (1976), Congress did neither. Section 1395ff provides for judicial review in the district courts after a governmental administrative hearing in controversies in which the Secretary is to make the initial decision. It is silent as to judicial or administrative review of reimbursement decisions to be made by carriers under Part B, not because Congress wished to foreclose premium paying beneficiaries from judicially enforcing their rights to benefits computed and paid pursuant to Part B, but rather at most because Congress considered that governmental administrative review and full judicial review in the district courts on the governmental administrative record was not necessary or appropriate for carriers' decisions. However, Congress left the Court of Claims as the one court with jurisdiction to render a money judgment for benefits in the event the benefits were not paid or computed consistent with the statute and Constitution.

Similarly 42 U.S.C. § 405(h) at most precludes any form of judicial review of decisions made *by the Secretary* other than the statutory judicial review provided for those decisions in

§§ 1395ff & 405(g). It is silent as to judicial review of decisions by private carriers. The United States' contention that a decision of a carrier is a decision of the Secretary for purposes of this statute is contrary to the plain meaning of the statute and inconsistent with the statutory scheme.

There being no unequivocal withdrawal of jurisdiction to adjudicate statutory and constitutional challenges to Part B benefit denials, the Court of Claims had jurisdiction over this matter under the Tucker Act. Its decision should be affirmed.

Moreover, the United States' interpretation of the Medicare statute to deny Court of Claims jurisdiction over Part B benefit claims raises serious constitutional issues. It means of necessity that no judicial or even governmental forum would be available to review unlawful or unconstitutional actions taken by private insurers as agents of the United States. This conclusion would place in serious doubt the constitutionality of the entire Part B private carrier payment mechanism. Such a dilemma need not be faced, however, since the Medicare statute can and should be interpreted to continue to allow the Court of Claims to exercise its limited jurisdiction over Part B claims.

Argument

I. Introduction: The Court of Claims' Analysis of its Jurisdiction Over Medicare Claims

The Court of Claims, in analyzing the extent of its own jurisdiction under the Medicare Act, has adopted a consistent and reasonable approach. It first has recognized the general rule that under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979), it has a broad grant of jurisdiction over non-tort claims for money damages against the United States. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 585. That broad grant of jurisdiction is explicit:

> "The Court of Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of

> Congress, or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort ...."

28 U.S.C. § 1491.

It then has determined that under the Medicare Act there is generally a substantive right of action against the United States for benefits either because of the United States' entering into contracts for payment of such benefits or because the Medicare Act, fairly read, mandates appropriate payment. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 58, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977); *Overlook Nursing Home, Inc.* v. *United States*, 214 Ct. Cl. 60, 556 F.2d 500 (1977).

Having recognized that general rule regarding its jurisdiction over Medicare Act claims, the Court of Claims has analyzed whether any action by Congress either has precluded it from exercising such jurisdiction over the particular types of claims asserted in a given case or has withdrawn the substantive right to damages for a particular class of claims. *Id.*; *Erika, Inc.* v. *United States*, *supra*, 634 F.2d at 585-88 (Pet. App. 7a-15a).

In the instant case each element of the Court of Claims' analysis compelled it to exercise jurisdiction: it has jurisdiction over non-tort claims for money damages against the United States and a general substantive right to such damages under Part B of the Medicare Act exists. Finally, nothing Congress has done has substantively eliminated Erika's rights to damages or repealed the Court of Claims' jurisdiction over the type of claim which Erika asserted. Therefore jurisdiction existed.

II. The Court of Claims Has Jurisdiction Over Claims for Benefits Under the Medicare Act

A. *Erika's Claim is a Non-Tort Claim Against the United States for Money Damages*

Under the Tucker Act, 28 U.S.C. § 1491 (1976 & Supp. III 1979), the Court of Claims has jurisdiction to render a money judgment against the United States on claims founded on the Constitution, federal statutes or regulations, on contracts, or on other non-tort causes of action.

Erika's claim was for money damages, from the United States, under an Act of Congress or upon an express or implied contract, or otherwise for damages in a case not sounding in tort. As the Court of Claims recognized, "[o]n its face, [Erika's] petition states a claim within [Court of Claims] jurisdiction under the Tucker Act." *Erika, Inc.* v. *United States, supra*, 634 F.2d at 585 (Pet. App. 7a).

Despite the surficial applicability of this broad grant of jurisdiction, the United States argues that Congress, in Part B of the Medicare program, implicitly repealed the Tucker Act, in part, so as to preclude the Court of Claims from exercising jurisdiction to enter a judgment for money damages for any claims under Part B of the Medicare Act, including Erika's claims. U.S. Br. at 20. In an apparent rephrasing of this assertion, the United States argues as well that under Part B of the Medicare program Congress has not granted beneficiaries and their assignees any judicially enforceable right to receive benefits computed in accordance with the statute. *Id.* at 38-42.

Looking first to the general rule, it is clear from the language of the Tucker Act that absent some affirmative action by Congress carving out an exception to that Act, the

Court of Claims would have jurisdiction to enter a money judgment on any valid claim under Part B. Even though a carrier is the entity which in the ordinary course would make payments to Erika, the United States is the source of the funds for the payments and the real party in interest in disputes over Part B benefits. 42 C.F.R. § 421.5(b) (1980); *Kuenstler* v. *Occidental Life Ins. Co.*, 292 F. Supp. 532, 535 (C.D. Cal. 1968). The United States acknowledges this. U.S. Br. at 27 n.24. Erika's claim is against the United States.

The Tucker Act, however, is only jurisdictional. *United States* v. *Testan*, 424 U.S. 392, 398 (1976). Any substantive right to money damages from the United States must be derived from contracts, statutes or regulations other than the Tucker Act itself. *Id.* Erika has such a substantive right.

B. *Part B Beneficiaries and Their Assignees Have a Substantive Right to Recover Money Damages From the United States*

The United States is deemed to have waived its sovereign immunity, and thus is subject to suit in the Court of Claims, when the claimant is owed money from the United States upon a contract, is owed money wrongfully retained by the United States, or when "any federal statute 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained.' " *United States* v. *Testan*, *supra*, 424 U.S. at 400, quoting *Eastport S.S. Corp.* v. *United States*, 178 Ct. Cl. 599, 607, 372 F.2d 1002, 1009 (1967); *Mosca* v. *United States*, 189 Ct. Cl. 283, 290, 417 F.2d 1382, 1386 (1969), *cert. denied*, 399 U.S. 911 (1970).

With respect to Erika's Part B claim, the United States has waived its sovereign immunity and created a substantive right to money damages both as a contractual and statutory matter. The United States contracted both with the part B bene-

ficiaries and with Prudential to pay the beneficiaries and their assignees in conformity with the statute. *See* 42 U.S.C. § 1395u (1976 & Supp. III 1979). Having sold and delivered goods and services to beneficiaries under Part B, and received assignments of those beneficiaries' claims for payment from Prudential and the United States, Erika has a contractual claim for benefits under Part B. *See Fox* v. *Harris*, 488 F. Supp. 488, 495 (D.D.C. 1980).

As a statutory matter, moreover, the Medicare legislation, fairly read, mandates appropriate payment to providers. *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 58, 536 F.2d 347, 351 (1976), *cert. denied*, 430 U.S. 969 (1977).

1. *Part B Beneficiaries and Their Assignees Have a Contractual Right to Payment of Benefits In Accordance With the Medicare Statute.*

The United States, both by enacting Part B as a voluntary program paid for in part by beneficiaries' premiums, and by authorizing and entering into contracts with carriers to supervise and process payments to Part B beneficiaries and their provider assignees, has created a contractual right to payment in accordance with the Medicare statute which is enforceable by the beneficiaries and their assignees.

a. *Erika Had An Implied-in-Fact Contract With the United States For Payment Pursuant to Part B of the Medicare Act.*

Implied-in-fact contracts with the United States have been a basis for the exercise of Court of Claims jurisdiction for many years. *E.g., Baltimore & O.R.R.* v. *United States*, 261 U.S. 592 (1923); *Scanwell Laboratories* v. *Shaffer*, 424 F.2d 859 (D.C. Cir. 1970); *Heyer Prods. Co.* v. *United States*, 135 Ct. Cl. 63, 140 F. Supp. 409 (1956).

A contract implied in fact is an agreement "founded upon a meeting of minds, which, although not embodied in an express contract, is inferred, as a fact, from conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding." *Baltimore & O.R.R.* v. *United States*, 261 U.S. 592, 597 (1923).

The relationship between Part B beneficiaries and the United States creates an implied-in-fact contract. The United States has offered to provide a supplemental insurance program which would entitle the program enrollees to certain medical expense reimbursement benefits. The beneficiaries accept that offer by voluntarily enrolling in the program. 42 U.S.C. § 1395p (1976). They pay "premiums" for their "medical insurance" under Part B. 42 U.S.C. § 1395r (1976 & Supp. III 1979). These premiums are paid into a trust fund separate and distinct from the fund established under Part A. If the beneficiary defaults in the payment of premiums, his or her coverage is terminated. 42 U.S.C. § 1395q(b)(2) (1976).

The analogy to a private insurance contract is too close to be ignored. The beneficiaries have accepted an offer, have parted with consideration, and there is a meeting of the minds. The beneficiaries are entitled to that for which they have paid. The benefits are described in terms of "entitlement", 42 U.S.C. § 1395k (1976 & Supp. III 1979), not of contingency or condition. It is unlikely that even the United States will argue that it was anyone's understanding that the beneficiaries pay their premiums in return for a promise which could be broken with complete impunity upon the whim, caprice or mistake of a private, profit-making insurer acting as a carrier.

Moreover, several elements in the relationship between Erika and Prudential point to a distinct contract implied in fact between them. Erika provided goods and services under an understanding that it would be paid for them in a manner and in an amount consistent both with the Medicare statute and Prudential's contract with the Secretary. There was a reasonable expectation that Prudential would authorize and

make payment for the goods and services. Assent to this understanding was expressed in the continued acceptance and payment (albeit partial) by Prudential for Erika's services. Consideration passed to the United States, since goods were sold and delivered to the beneficiaries of its statutory program, and since Erika detrimentally relied on the United States' promise to pay the "reasonable charges" for such services. Such consideration is a "fundamental" requirement for recovery under the Tucker Act, *Somali Dev. Bank* v. *United States*, 205 Ct. Cl. 741, 750, 508 F.2d 817, 822 (1974). Moreover, the value of the services provided to the government could either be used as support for a suit for the value of the services in quantum meruit, *Cities Serv. Gas Co.* v. *United States*, 205 Ct. Cl. 16, 500 F.2d 448 (1974), or for an action based upon a construction of the implied contractual term "reasonable charges" as including the statutory requirements for the computation of those charges. In *Cities Serv. Gas Co.* v. *United States*, *id.*, for example, the plaintiff had sold and delivered gas to the United States under an implied (but not express) contract. The Court of Claims exercised jurisdiction over the claim and held that the plaintiff could recover the value of all such gas on a quantum meruit basis in the absence of any price term in the implied-in-fact contract. *Id.* at 33, 500 F.2d at 457.

The United States, in entering into a contract with Prudential, has already waived its sovereign immunity as to claims under that contract. That contract, moreover, required Prudential to enter into a relationship with Erika to pay money to Erika for goods sold and delivered or services rendered. Erika's goods were not delivered gratuitously. The amounts of Prudential's payments for such goods and services were to be determined pursuant to statutory guidelines. All parties intended those payments to be made. Since Erika furnished goods and services to the beneficiaries of the Part B program, and Prudential, in effect, accepted or confirmed the ac-

ceptance of those goods and services, a contract for payment by Prudential to Erika for those goods and services must be implied in fact.

Both the United States' contract with Part B beneficiaries and Prudential's contract with Erika required Prudential to compute the amount of the payments consistent with its contractual and statutory authority and actually to make those payments. Because Prudential did not do so, Erika had a right to damages for the breach of those implied-in-fact contracts. That right was enforceable against Prudential's principal, the United States.

b. *Erika Could Sue As An Intended Third Party Beneficiary to Prudential's Contract With the United States.*

Even if no contract between Erika and Prudential or the United States could be implied in fact, Erika has the right as a third party beneficiary to enforce the contract between the Secretary and Prudential.

The Court of Claims has jurisdiction over third party beneficiary claims based upon a government contract. E.g., *Hebah* v. *United States*, 192 Ct. Cl. 785, 792, 428 F.2d 1334, 1339 (1970) ("It is settled, moreover, that an intended third-party beneficiary of a government contract may sue under § 1491"); *accord*, *Maneely* v. *United States*, 68 Ct. Cl. 623, 629 (1929); *Deltec Corp.* v. *United States*, 164 Ct. Cl. 432, 328 F.2d 1004 (1964).

As this Court has recognized, when a contract is plainly for the benefit of a non-contracting party, that party has the right to enforce it. *Crumady* v. *The Joachim Hendrik Fisser*, 358 U.S. 423, 428 (1959), *citing with approval*, *Restatement, Law of Contracts*, § 133. In the classification of the *Restatement (Second) of Contracts*, Erika is an "intended" beneficiary. *Restatement (Second), of Contracts* § 133 (1973). "... [A] beneficiary of a promise is an intended beneficiary if recognition of a right to performance in the beneficiary is appropriate

to effectuate the intention of the parties and the circumstances indicate that the promisee intends to give the beneficiary the benefit of a promised performance." *Id.*

The intent of the Secretary's contract with Prudential was clearly to benefit Medicare beneficiaries and their suppliers. The statutory purpose of the Medicare program is to convey a benefit to aged or disabled beneficiaries. The provisions for establishing reasonable reimbursement to those suppliers who undertake to provide goods and services to covered persons are manifestly for the benefit of both the covered person and the supplier.

The Secretary's purposes in contracting with Prudential were expressly consistent with and in furtherance of the purposes of the Medicare statute. Performance of Prudential's contractual promise to provide reimbursement "benefits" to individual recipients or their assignees was intended by both promisor and promisee. Prudential's performance in making payments was to be rendered directly to beneficiaries and assignees, not to the United States.

Moreover, individual beneficiaries and/or their assignees had to participate, cooperatively, in the payment process for Prudential's performance to occur. The beneficiaries and their assignees were sufficiently defined and described in the contract so as to be identifiable. Prudential could reasonably foresee that its failure to perform would cause harm to beneficiaries and their assignees. In addition, Prudential, to the knowledge of the promisee, viewed reimbursement of beneficiaries in accordance with the statute as its obligation in exchange for the consideration promised to Prudential.

Erika could even be classed as a creditor beneficiary. The Secretary has a statutory obligation to reimburse beneficiaries and their assignees for all covered "fair and reasonable" charges. In order to carry out this obligation, the Secretary "is authorized to enter into contracts with carriers" such as Prudential. 42 U.S.C. § 1395u(a) (1976). Prudential, in con-

sideration of funds received from the United States, promised to "make determinations of the rates and amounts of payments required . . . to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable)", *id.* § 1395u(a)(1)(A), and to "receive, disburse and account for funds in making such payments." 42 U.S.C. § 1395u(a)(1)(B). Erika, having provided goods and services in reliance on the statute and on Prudential's obligation to comply with its contract in making payments to Erika, is a creditor beneficiary of this contract. It therefore may sue for its enforcement.

The United States contracted with Prudential to have Prudential take certain actions with respect to setting the levels of payment and making payment to Medicare beneficiaries. Entry into that contract constituted a waiver of sovereign immunity with respect to enforcement of its provisions.

That waiver of sovereign immunity is broad enough to cover any judicially cognizable claim on the contract, whether it is a claim by Prudential, by a third-party beneficiary or by a party to a new contract entered into by Prudential as agent for the United States. In the absence of express limitations on that waiver, the Court of Claims has jurisdiction, therefore, to adjudicate claims for reimbursement under Part B of Medicare.

2. *The Medicare Legislation, Fairly Read, Mandates Appropriate Payment to Providers*

Even apart from the waiver of sovereign immunity implicit in the United States' contracting with Part B enrollees, with Prudential and with Erika, the Medicare Act itself mandates a judicially enforceable substantive right to payment. The Court of Claims has consistently recognized this principle, *e.g.*, *St. Elizabeth Hosp.* v. *United States*, 214 Ct. Cl. 322, 326-27, 558 F.2d 8, 11 (1977); *Whitecliff, Inc.* v. *United States*, *supra*, at 58, 536 F.2d at 351; *Alabama Hosp. Assn.* v. *United States*, No. 465-79C (Ct. Cl. June 17, 1981).

The Medicare statute on its face requires payment to beneficiaries and providers. 42 U.S.C. § 1395u (1976 & Supp. III 1979). Its description of Part B benefits is in terms of "entitlement", *id.* § 1395k, language which is mandatory, not permissive. *See Selman* v. *United States*, 204 Ct. Cl. 675, 498 F.2d 1354 (1974). If beneficiaries and suppliers are "entitled" to payments, as a general proposition they must be entitled to compel payment of benefits wrongfully withheld. *See Marbury* v. *Madison*, 5 U.S. (1 Cranch.) 135, 162 (1803). The beneficiaries, never knowing whether they would be personally liable for 100 per cent or 20 percent of the costs of their kidney dialysis or other medical treatment, would have neither insurance nor security under this health insurance part of the Social Security program. On the other hand, if suppliers were not so entitled but were dependent solely on an unenforceable commitment that they might be paid under Medicare, their willingness to cooperate with the program, to ship on less than C.O.D. terms and indeed to enter into the market would be jeopardized, all to the detriment of the would-be Medicare beneficiaries. The ability to enforce a right to payment must be implicit in a fair reading of the Medicare statute.

> We cannot believe that Congress intended in 1965 that Medicare providers would be "entitled" to whatever reimbursement the Secretary (or fiscal intermediary) granted, be it high or low, fairly or unfairly set. The Medicare Act does not, of course, show any legislative intent to aid providers of care for their own sakes . . . The Congressional concern was rather for the Act's beneficiaries. *Id.* Yet making provider reimbursements unreviewable would doubtless chill the provision of care to beneficiaries, or perhaps worse, would encourage providers to cheapen the care given to Medicare patients. More unscrupulous providers might choose to offset insufficient Medicare reimbursements by charging higher fees to non-Medicare patients. This would contravene one objective of the Act,

> which is that "the costs of services of [sic] individuals covered by the program will not be borne by individuals not covered ..." S.Rep. No. 89-404, 89th Cong., 1st Sess., *as reprinted in* 1 [1965] *U.S. Code Cong. & Admin. News.* pp. 1943, 1976.

Chelsea Community Hosp. v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1136 (6th Cir. 1980) (citations omitted).

For the government to accept the funds of older or disabled Americans in return for a promised benefit of crucial importance to them, and yet to have their right to that benefit totally subject to the errors or even whims not only of governmental agencies, but also of private, profit-making carriers, with no recourse to judicial review, is so unacceptable that the government's argument must fail. The United States can reasonably, albeit incorrectly, assert that Congress has circumscribed beneficiaries' rights to judicial review, but for it to suggest that Part B of the Medicare Act, fairly read, does not give its beneficiaries enforceable rights to benefits, argues too much. A right to judicial enforcement of a Part B beneficiary's rights must be mandated by the Medicare statute.

As a corollary, judicial enforcement of a right to payment *in accordance with the statutory scheme* must be implicit in the statute. Indeed, payment could not lawfully be mandated except in accordance with the statute.

The Court of Claims has therefore repeatedly held that 28 U.S.C. § 1491 (1976 & Supp. III 1979) confers jurisdiction upon it to resolve claims for Medicare reimbursement, including claims by providers for reimbursement, unless specific legislation provides that judicial review is available exclusively elsewhere or that jurisdiction in the Court of Claims is clearly precluded. *Appalachian Regional Hosps., Inc.* v. *United States*, 217 Ct. Cl. 1, 8, 576 F.2d 858, 861-862 (1978), and cases cited. Thus, unless Congress has acted expressly to preclude actions in the Court of Claims relating to Part B benefit determinations, such actions are within the Court of Claims' jurisdiction.

The Government's jurisdictional argument in essence is that Congress has carved out such an exception to that general grant of jurisdiction and waiver of sovereign immunity. None of the Congressional actions referred to by the Government, however, either deprived the Court of Claims of its jurisdiction under the Tucker Act to decide this case or withdrew the waiver of sovereign immunity inherent in the Medicare contracts and statute.

III. Congress Did Not Preclude Review of Part B Benefit Determinations in the Court of Claims

The United States' contention that Congress deprived the Court of Claims of jurisdiction in this matter rests on two arguments:

1. That 42 U.S.C. § 1395ff (1976) provides for a particular form of administrative and judicial review of decisions as to the amount of, and eligibility for, certain Part A benefits and as to eligibility for Part B benefits, but is silent as to judicial review of Part B benefit determinations. The United States argues, therefore, that Congress thereby intended to preclude all judicial scrutiny of Part B benefit determinations. The United States also quotes legislative history of the Medicare Act and amendments suggesting that the decision not to include statutory language specifically permitting judicial review of a determination of the amount of Part B benefits was deliberate.

2. That Section 205(h) of the Social Security Act, 42 U.S.C. § 405(h) (1976), applicable through 42 U.S.C. § 1395ii (1976), precludes all judicial review of the carrier's determinations under Part B.

The Government's burden on this issue is a very heavy one: it must provide "clear and convincing" evidence of congressional intent before this Court will construe a statute to restrict

access to judicial review. *Johnson* v. *Robison*, 415 U.S. 361, 373-74 (1974).[7] "[J]udicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967) and cased cited.

A. *42 U.S.C. § 1395ff Does Not Deprive the Court of Claims of Jurisdiction in This Matter*

The United States contends that 42 U.S.C. § 1395ff (1976), because it provides for administrative and judicial review of certain Medicare disputes but is silent as to Part B benefit determinations, implicitly deprives the Court of Claims of jurisdiction over this matter. However, neither the statutory language nor the legislative history compels that conclusion.

42 U.S.C. § 1395ff (a) (1976) provides, in pertinent part, that the Secretary will make a determination as to:

> (1) whether an individual is eligible under Part A of Medicare,
>
> (2) whether he or she is eligible under Part B of Medicare, and
>
> (3) the amount of benefits under Part A.

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[7] The United States attempts to avoid this issue by arguing that *Johnson* v. *Robison* dealt only with preclusion of judicial scrutiny of constitutional issues, and that the majority below found Erika's constitutional claims insubstantial. The issue cannot be so easily avoided. The United States' claim that the Medicare statute deprived the Court of Claims of jurisdiction to review carriers' decisions would apply regardless of the substantive basis for the provider's attack on the carrier's decision, whether that basis is statutory, contractual, equitable or constitutional. There is no principled basis for creating a constitutional issue exception to the argument, and the United States proffers none. Indeed, in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), this Court made it clear that if review of a Social Security Act claim were statutorily precluded, the presence of a constitutional claim to benefits under the Act would not overcome the statutory preclusion of review. *Id.* at 760-61.

Moreover, there is a presumption in favor of judicial review of any agency decision, *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967), and regardless of how the government's burden is characterized, it is a heavy one.

Under § 1395ff(b), an individual dissatisfied with the determination by the Secretary on any of these issues is entitled to an administrative hearing by the Secretary and to judicial review of the Secretary's final decision. That section also provides that no such *administrative* hearing as to the amount of Part A benefits is available if the amount in controversy is less than $100. Likewise, the statute expressly states that no *judicial* review of the Secretary's determination as to the amount of Part A benefits is available if the amount in controversy is less than $1,000.

Section 1395ff is silent regarding determinations as to the amount of Part B benefits. The Government argues that that silence implicitly evidenced a preclusion of judicial review of Part B determinations.

However, the most readily apparent reason why § 1395ff, which relates to decisions required to be made by the Secretary, is silent as to judicial review of Part B benefit determinations, is that such determinations are to be made by carriers, rather than by the Secretary. *See* 42 U.S.C. § 1395u (1976 & Supp. III 1979); Report of the Senate Committee on Finance, S. Rep. No. 404, Part I, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1995. It is under a different section of the statute that those carriers are required, by statute and contract, to have their own determination and private administrative review proceedings completely separate from the decisions by the Secretary and governmental administrative hearings provided for in § 1395ff. 42 U.S.C § 1395u(b)(3)(C) (1976). The carrier is required to:

> establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to ser-

> vices furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy . . . .

(*id.*)

The administrative hearing provisions of § 1395ff, which provide for hearings by the Secretary on decisions to be made by the Secretary, are silent as to administrative hearings by the Secretary on matters in which carriers are required to make the decisions and to provide the hearings themselves under § 1395u(b)(3)(C). The absence of a specific authorization under § 1395ff for administrative review by the Secretary and judicial review thereafter of Secretarial decisions regarding the amount of Part B benefits is thus merely consistent with the fact that there are to be no decisions by the Secretary on those issues. Carriers, rather than the Secretary, are to make those particular determinations, and the hearings to be conducted by the carriers are provided for in § 1395u, not § 1395ff.

Moreover, while in § 1395ff Congress *expressly* precluded judicial review of certain classes of disputes, it was silent as to judicial review of Part B benefit determinations. Silence in § 1395ff on that issue cannot be taken to be the equivalent of Congress' deliberate affirmative preclusion of judicial review of other classes of cases in the same section.

The Government argues, however, that in the legislative history of § 1395ff, the Senate Committee on Finance made the following parenthetical comment to the description of the requirements of hearings by the Secretary contained in § 1395ff:

> . . . (Under the supplementary plan, carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits, and the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A.) . . . .

Report of the Senate Committee on Finance, S. Rep. No. 404, art I, 89th Cong., 1st Sess. 54-55, *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1995.

That statement, however, is far from the unambiguous evidence of intent to withdraw Court of Claims' jurisdiction that the Government claims. Administrative remedies under Part B were in fact provided in another section of Title 42 (§ 1395u). At most, the legislative history quoted above indicates that the bill *was deliberately silent* as to judicial review of Part B determinations of the amount of benefits, not that Congress intended that all judicial scrutiny of Part B determinations be prohibited. In view of the fact that Congress was delegating governmental powers to private parties, it is more reasonable to interpret the silence of the statute and the legislative history to mean that while judicial review was not to be augmented by the full review procedures described for Part A determinations, it was still to be available to the extent of the courts' existing jurisdiction. Congress, in the legislative history of § 1395ff, to the extent it dealt at all with administrative decisions under § 1395u, thus merely refused to specify a particular manner in which the carriers' decisions were judicially reviewable. It thereby left the scope of such review to the courts' existing jurisdiction.

The Court of Claims considered this legislative history and read it as precluding ordinary judicial review of the *amount* of a particular benefit determination, not as precluding all judicial consideration of constitutional and statutory challenges to administrative actions which might have an effect on the benefit determinations. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 587-88 (Pet. App. 14a). Such a reading was entirely consistent with the Court of Claims' rulings in *Goldstein* v. *United States*, 201 Ct. Cl. 868, *cert. denied*, 414 U.S. 974 (1973), *Appalachian Regional Hosps., Inc.* v. *United States, supra* at 8, 576 F.2d at 861-62, and *Whitecliff, Inc.* v. *United States, supra* at 57-58, 536 F.2d at 350-51, restricting its jurisdiction in such cases to review of statutory and constitutional claims.

Indeed, the position of the Court of Claims is in complete harmony with the legislative framework. In § 1395ff, Congress was specifying a very particular type of remedy for review of decisions to be made by the Secretary. It provided for a formal hearing analogous to the type of hearing provided under the Administrative Procedures Act, 5 U.S.C. §§ 551 *et seq.* (1976 & Supp. III 1979) (assuming the jurisdictional amount was satisfied) and thereafter for full judicial review in the district courts pursuant to 42 U.S.C. § 405(g) (1976). 42 U.S.C. § 1395ff(b)(1) (1976). Indeed § 405(g) permits judicial review in the district court in the plaintiff's own district, a right of considerable practical importance. The scope of review is on a "substantial evidence" basis and the reviewing court is given broad remedial powers.

Those remedies, at least in that form, are not available for Part B benefit determinations. There is no governmental administrative hearing and no decision by the Secretary. Review in the district courts is apparently precluded (*see* discussion at 32-33 *infra*). The broad remedial powers of a district court, and its ability to review the full breadth of administrative decisions on the record, are denied Part B beneficiaries.

The residuary jurisdiction of the Court of Claims, limited to granting money judgments, or the equivalent in a remand order, and restricted solely to determining whether the statute and Constitution have been complied with, constitutes something far less than judicial review of an administrative decision in any customary manner. Such relief is only a judicial mechanism to require the carrier and the United States to pay the beneficiary that to which it is clearly entitled by statute, contract and the Constitution.

To say that because Congress chose not to give Part B beneficiaries as broad rights as it gave Part A beneficiaries, it therefore chose to deprive Part B beneficiaries of all rights to judicial scrutiny of adverse Part B benefit determinations, is not logical. Congress could certainly have expressed an intent to restrict full "judicial review" similar to that provided in the

Administrative Procedures Act for a given class of cases, without intending to foreclose a beneficiary from obtaining *any* judicial remedy for a refusal by a carrier to pay what is statutorily and constitutionally required.

The few sentences of legislative history cited by the Government are ambiguous and far too uncertain a basis on which to ground the Government's drastic conclusion. In the absence of clear Congressional intent to the contrary, the Court of Claims was not barred from exercising its jurisdiction under 28 U.S.C. § 1491. *See Johnson* v. *Robison*, 415 U.S. 361, 373 (1974); *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967).

B. *42 U.S.C. § 405(h) Does Not Preclude Court of Claims Jurisdiction Over Part B Benefit Determinations*

1. *The United States' Position Unnecessarily Raises Serious Constitutional Questions.*

The United States also argues that § 205(h) of the Social Security Act, 42 U.S.C. § 405(h) (1976), precludes all judicial review of Part B benefit determinations. Its reasoning raises serious constitutional questions.

Section 405(h) provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, of any officer or employee thereof shall be brought under sections 1331 and 1346 of title 28 to recover on any claim arising under this subchapter.[8]

That section is adopted by reference for the Medicare program, with conditions, in 42 U.S.C. § 1395ii (1976):

[8] The 1976 edition of the United States Code, quoted above, has not been enacted into positive law. In the 1970 edition, "sections 1331 and 1346" of title 28 are referred to as "section 41" of title 28, the designation contained in the Social Security Act. For clarity the current designation is used herein.

> "the provisions of . . . subsection . . . (h) . . . of section 405 of this title, shall also apply with respect to this subchapter to the same extent as [it is] applicable with respect to subchapter II of this chapter."

As originally enacted in the Social Security Act, § 405(h) was tied closely to § 405(g). The latter section provides a particular mechanism for judicial review in the district courts of final decisions by the Secretary. Thus, the preclusion of judicial review in the second sentence of § 405(h) was substantially softened by the exception to that preclusion, "except as herein provided", because § 405(g) did provide a judicial review mechanism.

In *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), this Court considered the effect of the preclusionary language of § 405(h) on district court jurisdiction. In that case the plaintiffs had attacked the constitutionality of certain sections of the Social Security Act. Jurisdiction in the district court over that constitutional claim was asserted by the plaintiffs under 28 U.S.C. § 1331.

This Court held that the third sentence of § 405(h) did in fact deprive the district court of jurisdiction under 28 U.S.C. § 1331 even to consider constitutional attacks on the Social Security Act. That third sentence reads: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 and 1346 of title 28 to recover on any claim arising under this subchapter."

Central to the *Salfi* opinion is this Court's recognition that it was *not* foreclosing constitutional claims from all judicial forums: it held that § 405(g) provided such a forum, in the district court statutory review procedures. Therefore, this Court did not have to deal with the serious problem which a preclusion of constitutional claims from all judicial scrutiny would have raised. It stated that such a restriction on the availability of judicial review "[n]ot only would . . . have been extraordinary, such that 'clear and convincing' evidence would be required before we would ascribe such intent to

Congress, . . . but it would have raised a serious constitutional question of the validity of the statute as so construed." 422 U.S. at 762 (citations omitted). The *Salfi* decision was reaffirmed in *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

In the Medicare Act, however, § 405(h) was adopted by reference *without* the accompanying statutory review provisions of § 405(g). 42 U.S.C. § 1395ii (1976). The saving judicial review provision of § 405(g) thus is not available to avoid the constitutional dilemma which § 405(h) otherwise would have caused in *Salfi*.

Since *Salfi*, the United States has repeatedly precipitated that serious constitutional dilemma by apparently seeking to have all judicial forums for review of Medicare Part B benefit determinations and certain Part A statutory and constitutional claims closed. For example, in *United States* v. *Aquavella*, 615 F.2d 12 (2nd Cir. 1979), the United States unsuccessfully contended that because of § 405(h), a determination made by a Part A fiscal intermediary and affirmed by HEW that funds were owed to HEW by a provider could not be reviewed in any forum, even by the district court with jurisdiction over the United States' claim to recover those funds. In the instant case, the United States' contentions are equally broad:

> . . .[N]o "tribunal"—in this case, the Court of Claims—may review the carriers' findings of fact or decision except as otherwise provided in the Medicare Act itself. Since nothing in the Medicare Act provides for judicial review in these circumstances, review is barred by the literal terms of the second sentence of 42 U.S.C. § 405(h). . . .

U.S. Br. at 34.

> ". . .Indeed, by the cumulation of prohibitions in 42 U.S.C. § 405(h), Congress clearly has manifested its intent to foreclose all review of administrative findings and conclusions in this context. . . .

U.S. Br. at 35 n.32.

Chief Justice Marshall's discussion in *Marbury* v. *Madison*, 5 U.S. (1 Cranch.) 135 (1803) underscores the inherent infirmity of the United States' position here:

> "...[W]here a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems equally clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy."

5 U.S. at 165, 1 Cranch. at 166.

> "The government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right.

5 U.S. at 162, 1 Cranch. at 163.

> "The question whether a right has vested or not, is, in its nature, judicial, and must be tried by the judicial authority...."

5 U.S. at 165, 1 Cranch. at 167.

The United States argues for an interpretation of a federal law, silent as to judicial review of the decisions of a private carrier, which would preclude all judicial scrutiny of contractual, statutory and constitutional violations by the carrier. It claims, moreover, that the federal government can by contract delegate governmental functions to a private party and yet preclude a person injured by the blatantly illegal acts of that party, in violation of its contract, from obtaining any judicial relief from those illegal acts. Even if the Medicare statute and the Tucker Act were ambiguous, they should be interpreted so as to avoid such a result. *Johnson* v. *Robison*, 415 U.S. 361 (1974).

The United States seeks to avoid this serious constitutional issue by arguing that this Court should reverse the decision below without facing the issue of whether the Court of Claims

has jurisdiction to decide constitutional claims under Part B. That assertion is erroneous. With respect to Medicare benefit decisions, this Court has stated that pursuant to 42 U.S.C. § 405(h), there is no jurisdiction in the district courts under 28 U.S.C. § 1331 to review constitutional challenges to the Social Security Act. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975). With respect to Part B Medicare carrier decisions, no § 405(g) review proceedings are provided. Section 405(h) thus applies to preclude § 1331 jurisdiction over such constitutional claims in the district courts and no other district court jurisdiction is granted.[9] The United States asserts that the Court of Claims is precluded from reviewing carrier decisions by the same statutory language and hence to the same extent as the district courts. Of necessity it is therefore asserting that no judicial forum has jurisdiction over colorable claims that a carrier has violated the Constitution.

This case need not require this Court to determine whether Congress can circumvent the Constitution by delegating the powers of the United States to private parties and than allow-

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[9] It has been suggested that the district courts might have mandamus jurisdiction over Part B claims under 28 U.S.C. § 1361 (1976). See *Mathews* v. *Eldridge*, 424 U.S. 319, 332 n.12 (1976). That statute, however, only gives district courts jurisdiction "to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." It is doubtful whether Prudential is an "officer or employee" of the United States or any agency. Whether the Secretary could be compelled in a mandamus action to enforce his contract with Prudential, and thus indirectly to allow Erika the relief to which it is entitled, is equally doubtful. Nothing express in the Medicare statute requires the Secretary to take action to enforce every term of every contract into which he has entered. Mandamus ordinarily lies only to enforce a nondiscriminatory, ministerial duty to act that is so plainly prescribed by law as to be free from doubt. *See Wilbur* v. *United States*, 281 U.S. 206, 218-19 (1930); *Cervoni* v. *Secretary of HEW*, 581 F.2d 1010, 1019 (1st Cir. 1978) ("The mandamus remedy is only available under exceptional circumstances of clear illegality.") In any event, the United States' claim that 42 U.S.C. § 405(h) prohibits all judicial scrutiny of part B decisions would, if upheld, apply to District Court "nonstatutory" review to the same extent that it would apply to Court of Claims review.

ing the private parties to violate the statute, the Constitution and their contracts without judicial constraint. If the United States' interpretation of the statute were upheld, that serious, indeed monumental constitutional issue would have to be addressed.

In *McClure* v. *Harris*, 503 F.Supp. 409 (N.D. Cal. 1980), the district court was faced with a related constitutional dilemma. The plaintiff in *McClure* had challenged, under the due process clause, the constitutional adequacy of Part B hearing procedures. In particular the challenge focused on the fact that Part B hearing officers are tied to the carriers by the power of appointment and often as well by employment and other pecuniary interests, that they are given little or no formal training and are not required to meet any threshold qualifications for employment. The district court apparently assumed that there was no judicial or administrative review available from an adverse carrier hearing. "...[I]f no independent tribunal is ever to review a hearing officer's decision, then impartiality must be fully ensured at the hearing-officer level." *Id.* at 414. It therefore concluded that the Part B procedures were not impartial or constitutionally adequate and declared the entire system of carrier "fair hearings" to be unconstitutional. Had the district court been aware of a right to judicial review, its decision might well have been different.

The United States has sought to appeal *McClure* v. *Harris* to this Court. *See* U.S. Br. at 23 n.20. The constitutional issue in *McClure* v. *Harris*, in Erika's view, may be at least partially avoided by recognizing the right to overturn carrier statutory and constitutional violations through a suit for damages in the Court of Claims.

2. *42 U.S.C. § 405(h) Should Be Read Not To Preclude Court of Claims Jurisdiction.*

Faced with this Court's ruling in *Salfi*, and the United States' insistence that all channels of judicial relief for Part B benefit claims and certain Part A claims have been closed,

the Courts of Appeals, the Court of Claims and numerous district courts have acknowledged the constitutional dilemma posed by the United States' position, and have consistently interpreted § 405(h) to avoid that dilemma. Despite differing specific interpretations, a common thread runs through these decisions: § 405(h) need not and should not be interpreted to indicate a congressional intent to eliminate all "nonstatutory" district court and Court of Claims review.

For example, in *St. Louis Univ.* v. *Blue Cross Hosp. Serv.*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976), the Eighth Circuit purported to follow *Salfi* in a Medicare case involving both Part A and Part B issues. It held that while § 405(h) deprived the district court of § 1331 jurisdiction over a claim for Medicare payments, it did not deprive it of jurisdiction under § 1331 to require a constitutionally adequate hearing as to Medicare benefits. The Eighth Circuit rested its decision in substantial part on the perception that no judicial review of the due process claim would otherwise be available under the Medicare Act, 537 F.2d at 293.

In *Trinity Memorial Hosp. of Cudahy, Inc.* v. *Associates Hosp. Serv., Inc.*, 570 F.2d 660 (7th Cir. 1977), the plaintiff claimed that under Part A it was entitled to an additional payment of reimbursable costs both on statutory and constitutional grounds. Such a claim fell outside the scope of the § 405(g) review procedures, and the United States argued that § 405(h) therefore precluded all judicial review. 507 F.2d at 666. The Seventh Circuit agreed that § 405(h) deprived the district courts of § 1331 jurisdiction, specifically disagreeing with the Eighth Circuit holding in the *St. Louis University* case, *supra*. It stated, however, that "[t]here can be little doubt that the Court of Claims has jurisdiction . . ." over a due process Part A reimbursement claim, 570 F.2d at 667, thus avoiding the constitutional issue.

The Fifth Circuit, in *Dr. John T. MacDonald Foundation, Inc.* v. *Califano*, 571 F.2d 328 (5th Cir.), *cert. denied*, 439

U.S. 893 (1978), agreed with the Seventh Circuit. It held that § 405(h) precludes district court review of constitutional claims under the Medicare Act, but it did so only in light of its view that Court of Claims jurisdiction was not barred by § 405(h). 571 F.2d at 332. *Accord, South Windsor Convalescent Home, Inc.* v. *Mathews*, 541 F.2d 910 (2nd Cir. 1976).

In *Chelsea Community Hosp.* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131 (6th Cir. 1980), the Sixth Circuit addressed both *Salfi* and § 405(h) directly. It stated that *Salfi*, and the restrictions in § 405(h), made sense only in context, that is, only under the Social Security Act which provided alternative review in § 405(g). It reasoned that in the Medicare context, incorporation of § 405(h) by reference "as applicable," 42 U.S.C. § 1395ii (1976), did not show "clear and convincing" Congressional intent to preclude review. Rather, § 405(h) "does not have a meaningful application in a case where no statutory review mechanism is available, for the purpose of § 405(h), following *Salfi*, is 'simply the enforcement of the [42 U.S.C.] Section 405(g) procedures and prerequisites to judicial review.' " 630 F.2d at 1135, citation omitted.

The Second Circuit, in *United States* v. *Aquavella*, 615 F.2d 12 (2nd Cir. 1979), was squarely presented with the constitutional dilemma, since in that case there was no basis for Court of Claims' jurisdiction. (The United States was seeking a money judgment against Aquavella.) It held that the first sentence of § 405(h) by its terms does not apply to findings and decisions not made by the Secretary; that the second sentence is irrelevant when no alternative method of review is provided under the Medicare Act; and that the third sentence by its terms only applies to claims against the United States under 28 U.S.C. §§ 1331 or 1346. 615 F.2d at 19. It therefore found no congressional intent to deprive claimants of a right to sue in the Court of Claims or to preclude other forms of "nonstatutory" judicial review. *Id.* at 20.

The Court of Claims has consistently agreed with the opinions of the Circuit Courts of Appeals that Congress did not intend

to foreclose all Medicare claims from judicial review. In *Whitecliff, Inc.* v. *United States*, 210 Ct. Cl. 53, 536 F.2d 347 (1976), *cert. denied*, 430 U.S. 969 (1977), that Court held that § 405(h) did not prevent a provider under Part A from bringing an action for a money judgment in the Court of Claims when the statutory provisions for review in the district court were unavailable. In *Whitecliff*, as in the instant case, the administrative decision resulting in the claim was made by a private party (a "fiscal intermediary" under Part A) with the only administrative review available a hearing before a private appellate board. The Court of Claims, in rejecting the government's contention, was particularly influenced by the fact that to accept the government's contention "would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations . . ." 210 Ct. Cl. at 58, 536 F.2d at 350.

The Court of Claims' decision, like the decisions of the Circuit Courts of Appeals, is consistent with the language of the statute. The Government asserts that a decision by a carrier after a hearing conducted by the carrier is included within the language of the first sentence of § 405(h): "findings and decisions of the Secretary after a hearing . . . ." Giving the statutory language its plain meaning, however, Prudential is not the Secretary of Health and Human Services,[10] and the first sentence of § 405(h) simply does not apply.

The second sentence likewise refers to findings and decisions "of the Secretary." That language does not apply to a decision of a private carrier. Moreover, § 1395ff distinguishes between determinations to be made by the Secretary and determina-

[10] Congress manifested its intent to have different decisionmakers address different classes of decisions, even though ultimately the United States is the real party in interest in defending the decisions of both. *See* discussion *supra* at 13. The fact that the United States is the real party in interest in defending the decisions of both decisionmakers does not compel the conclusion that Congress considered the decisionmakers to be one and the same.

tions to be made by others, and specifically allows judicial review under § 405(g) only as to those decisions required to be made *by the Secretary*. Section 405(h), read together with § 405(g), simply does not relate to carrier decisions.

Section 1395u, which sets forth the procedures to be followed by carriers, in no way equates a decision by a carrier with a decision by the Secretary. It is unlikely that Congress would clearly distinguish in §§ 1395ff & 1395u between proceedings to be conducted by the Secretary and proceedings to be conducted by a carrier, while in another section intending that a reference to a decision by the "Secretary" be construed as a decision by the carrier.

In addition, the specific preclusion by the third sentence of § 405(h) of actions in the district courts under section 41 of title 28 (28 U.S.C. §§ 1331 & 1346) to recover on a claim for benefits under Part B of Medicare lends support to the continued exercise of Court of Claims jurisdiction as the appropriate forum for such cases. If Congress had wanted to preclude Court of Claims' jurisdiction, it knew how to do so explicitly. It specifically and deliberately precluded certain district court jurisdiction. Its silence as to the Court of Claims indicates that it did not intend to preclude Court of Claims jurisdiction.

The United States has asserted that "[i]t is most unlikely that Congress would have intended to permit an individual beneficiary or his assignee to *sue the United States* to recover on a claim that has been denied by a carrier, when Congress has not provided any prior opportunity for administrative review by expert agency officials in HHS . . . ." U.S. Br. at 26 (Emphasis in original). It is even more unlikely that Congress would intentionally permit a private party to make decisions involving many millions of public dollars, affecting medical insurance benefits of crucial importance to millions of Americans, and yet allow those decisions to be absolutely final, binding on the government and on private parties, subject to no scrutiny whatsoever by any government officer, agency, public body or court.

IV. The Decision Neither Opens the Floodgates to New Litigation Nor Changes Existing Law in Any Significant Way

The Government has implied that the decision below would open the floodgates to litigation:

> "... [m]ore than 150 million reimbursement claims are now filed under Part B each year. Statistics compiled by the Department of Health and Human Services disclose that during calendar year 1980, Part B carriers such as Prudential received 2,163,786 requests for informal review of their initial determinations. See 42 C.F.R. 405.807 *et seq.*; note 18, *supra*. The carriers affirmed their initial determinations in 975,143 of these cases. During the same period, carriers received 26,171 requests for "fair hearings," and their determinations were upheld after a hearing in 7191 cases. If only a fraction of the total number of disappointed claimants were to seek review in the Court of Claims or the district courts, the cited statistics demonstrate that there would be a significant increase in the workload of these courts. This would, in turn, strain the scarce resources of the Secretary and the Attorney General in defending against relatively minor monetary claims ...

U.S. Br. at 32-33

That contention is unrealistic. As an initial matter, the expense of litigating in the Court of Claims would of its own force screen out all but the most substantial disputes. The Government cannot seriously contend that the Court of Claims' docket is likely to become cluttered with $50 (or even $500) cases.[11] In any event the Court of Claims, which should be most familiar with its own docket, did not share the Government's opinion that that Court might become over-

[11] The instant case involves hundreds of thousands of dollars, by Erika's calculations.

burdened or even that the resources of the Secretary would be overtaxed by a sudden influx of cases into the Court of Claims. *Erika, Inc.* v. *United States, supra*, 634 F.2d at 588 (Pet. App. 14a-15a).

Furthermore, the instant decision of the Court of Claims did not change its prior view of its jurisdiction. The Court of Claims merely followed a long line of precedent, including *Goldstein* v. *United States, supra; Appalachian Regional Hosp., Inc* v. *United States, supra; Whitecliff, Inc.* v. *United States, supra. See Overlook Nursing Home, Inc.* v. *United States, supra.* The "floodgates" have in fact been open for years, but the resultant "flood" of litigation appears to have consisted primarily of Erika's suit.

Indeed, the fact that the Court of Claims has jurisdiction over Part B issues has been so widely assumed and relied on that even the cases cited by the United States as denying federal district court jurisdiction over Part B claims often state that even if the district courts lack such jurisdiction, the Court of Claims is one forum which has it. For example, the United States cites *Bussey* v. *Harris*, 611 F.2d 1001 (5th Cir. 1980), to support the proposition that several decisions of Courts of Appeals hold that there is no right of judicial review *in the district courts* of a carrier's benefit determinations under Part B. (U.S. Br. at 31). The *Bussey* v. *Harris* court also stated, as one of the factors in support of its decision:

> Review is available in the Court of Claims if litigants can state a claim for actual or nominal damages .... This holds true for Part B as well as for Part A actions ....
>
> Appellants could have sought damages in their complaint, although they instead requested declaratory and injunctive relief. Judicial review of any substantial constitutional or statutory claim, therefore, is available in the Court of Claims under 28 U.S.C. § 1491.

611 F.2d 1005 n.6. *Accord, Drennan* v. *Harris*, 606 F.2d 846, 850 (9th Cir. 1979) (also cited by the United States for the same proposition, U.S. Br. at 31); *Pushkin* v. *Califano*, 600 F.2d

486, 489-90 (5th Cir. 1979). *See Fox* v. *Harris*, 488 F.Supp. 488, 495 (D.D.C. 1980); *United States* v. *Bellevue Hosp. Inc.*, 479 F.Supp. 780, 784 (D. Mass. 1979). The Court of Claims did not announce anything in this case which has not been known and accepted by other courts, litigants and potential litigants for years.

Moreover, the Court of Claims' actions in this case were consistent with a severely limited view of its jurisdiction. The court found specific violations of the Medicare statute but refused to take the step of conducting a review of the "thousands" of individual benefit determinations the United States claims were at issue. Those it remanded to Prudential to determine consistent not only with the statute but also with the carrier's discretion:

> On the present record, we cannot determine what Erika's customary charges were for its drugs and services for each of the calendar years involved. Nor do we attempt to prescribe the method by which the carrier should make that determination. Prudential might decide to average the different charges made during the calendar year, or to allocate the different charges on the basis of the time each was in effect, or to determine the mean charge, or to use some combination of these methods. Perhaps Prudential can devise a better method of calculation.
>
> The selection of the appropriate method of calculation is for Prudential to determine in the first instance. The carrier has considerable discretion to adopt whatever method of calculation it concludes would most accurately measure and reflect Erika's customary charges during the preceding calendar year.

Erika, Inc. v. *United States, supra*, 634 F.2d at 589 (Pet. App. 17a).

> The regulations give carriers substantial flexibility in setting reimbursement rates to look at more than just the customary and prevailing charges .... The determination whether to grant particular adjustments and permit departures from prevailing charges during the preceding calendar year, however, is within the discretion of the carrier. We cannot direct Prudential whether or how to exercise that discretion in a particular case.

634 F.2d at 591 (Pet. App. 21a).

The Court of Claims has neither opened the floodgates of litigation nor acted in a manner which would encourage attempts to define away the carefully delineated limits on its jurisdiction.

Finally, mere recitation of possible administrative convenience as a reason for denying jurisdiction hardly establishes the requisite clear and convincing evidence of congressional intent to preclude review.

> ... [T]he agency harnesses that old workhorse, administrative convenience: we are told that given the complexity of provider reimbursements, "Congress reasonably assumed that to permit judicial review of the Secretary's determinations would unduly burden the already considerable administrative task." Judicial review is always inconvenient for administrators, as it is for everyone else involved. If administrative convenience were enough to destroy the presumption favoring judicial review of administrative action, that presumption would be a sham. Conjuring administrative inconvenience cannot "clearly and convincingly" show a legislative intent to preclude review.

Chelsea Community Hosp. v. *Michigan Blue Cross Ass'n*, *supra*, 630 F.2d at 1136.

Because a reasonable and principled alternative exists to deciding the constitutional questions of withdrawal of all avenues of judicial review, of improper delegation of judicial and executive authority to private parties and of the inadequacy of carrier-conducted administrative "review," that alternative should be chosen. *Johnson* v. *Robison, supra*. The jurisdiction of the Court of Claims should continue to be recognized, as limited by the court below, to include claims for money damages for statutory or constitutional violations in denying statutorily mandated payments to Part B Medicare beneficiaries and providers.

Conclusion

The decision of the Court of Claims should be affirmed.

Respectfully submitted,

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APPENDIX

42 U.S.C. §405:

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.*

42 U.S.C. §1395u:

(a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determination of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable):

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

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* In the 1976 edition of the United States Code, which has not been enacted into positive law, the reference to "section 41" is changed to refer to the present "sections 1331 and 1346" of Title 28.

(2)(A) determine compliance with the requirements of section 1395x(k) of this title as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1395x(k)(2) of this title) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contract with carriers under subsection (a) of this section may be entered into without regard to section 5 of Title 41 or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg(f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (II) the physician or other person furnishng such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y of this title, and if the individual to whom such service was furnished was without fault in incurring the expense of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physician's services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to heve been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirements in sub-paragraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this subchapter and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsis-

tent with the efficient and effective administration of the insurance program established by this part.

(5) No payment under this part for a service provided to any individual shall (except as provided in section 1395gg of this title) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e)(1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

based upon a voucher signed by a certifing officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in Paragraph (1)) with which an agreement is in effect under section 1395h of this title.

(g) The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 426(a) of this title and section 228s-2(b) of title 45.

42 U.S.C. §1395ff:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

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No. 80-1594

In the Supreme Court of the United States

OCTOBER TERM, 1981

UNITED STATES OF AMERICA, PETITIONER

v.

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

REPLY BRIEF FOR THE UNITED STATES

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UNITED STATES OF AMERICA, PETITIONER

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

REPLY BRIEF FOR THE UNITED STATES

Respondent contends that the amount of money it was paid by Prudential Insurance Company in reimbursement for numerous individual medical claims assigned to it by Medicare Part B beneficiaries was insufficient. Invoking the jurisdiction of the Court of Claims under the Tucker Act, 28 U.S.C. (& Supp. III) 1491, respondent brought suit for a money judgment against the United States for the amount of the alleged underpayment.

Respondent concedes (Resp. Br. 22-28, 31, 37) that nothing in the text of Part B of the Medicare statute confers a right to sue the United States for money damages in these circumstances and that there is no indication in the legislative history of a congressional intent to permit such suits. Indeed, respondent acknowledges (Resp. Br. 25-26) that the legislative history manifest a congressional intent to bar judicial review of benefit amount determinations under Part B. Respondent nevertheless argues that the Court of

Claims had jurisdiction of this case under the Tucker Act because (i) a right to judicial review of agency action must be presumed to exist ~~have~~ here absent "clear and convincing" evidence of congressional intent to the contrary, and (ii) the evidence of congressional intent to bar judicial review under Part B is not clear and convincing. Both arguments are incorrect, especially in the context of this case, in which jurisdiction is said to rest on the Tucker Act.

1.a. To reiterate the governing principles, "[i]t is elementary that '[t]he United States, as sovereign, is immune from suit save as it consents to be sued' " (*United States* v. *Mitchell*, 445 U.S. 535, 538 (1980), quoting *United States* v. *Sherwood*, 312 U.S. 584, 586 (1941)). For this reason, "the Court of Claims' jurisdiction to grant relief depends wholly upon the extent to which the United States has waived its sovereign immunity to suit" (*United States* v. *King*, 395 U.S. 1, 4 (1969)), and "such a waiver cannot be implied but must be unequivocally expressed" (*ibid.*, quoted with approval in *United States* v. *Mitchell, supra*, 445 U.S. at 538, and *United States* v. *Testan*, 424 U.S. 392, 399 (1976)). The Tucker Act itself does not contain the requisite waiver of sovereign immunity; that Act is only a jurisdictional statute. *United States* v. *Mitchell, supra*, 445 U.S. at 538. Therefore, respondent has a cause of action (and the Court of Claims had jurisdiction) in this case only if the Medicare Act itself contains an "unequivocally expressed" grant of a " 'substantive right enforceable against the United States for money damages' " (*ibid.*, quoting *United States* v. *Testan, supra*, 424 U.S. at 398).

b. In arguing that it had a right to bring the instant suit against the United States absent clear and convincing evidence to the contrary, respondent does not rely on decisions of this Court involving suits for money damages under the Tucker Act. Rather, it relies on cases brought in federal

district court seeking ordinary judicial review of agency action.

In the Administrative Procedure Act, Congress has explicitly waived the sovereign immunity of the United States and given consent to suits seeking judicial review of agency action (5 U.S.C. 702), except where judicial review is precluded by statute or the agency action concerned is committed to agency discretion (5 U.S.C. 701(a)). In these circumstances, Congress has in effect reversed the presumption against a right to sue the United States. See 1 *Moore's Federal Practice* para. 0.65 [2.-2], at 700.100 (2d ed. 1981). Accordingly, in such cases, "judicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." *Abbott Laboratories* v. *Gardner*, 387 U.S. 136, 140 (1967); see also *Johnson* v. *Robison*, 415 U.S. 361, 373-374 (1974). These cases, upon which respondent relies (Resp. Br. 22-23), have no relevance here. Suits seeking *money damages* are expressly excepted from the general waiver of sovereign immunity in 5 U.S.C. 702, and such suits therefore continue to be governed by the established rule that there is no right to money damages that is judicially enforceable against the United States unless Congress has affirmatively conferred that right in the particular statute under which the claimant sues. See, *e.g.*, H.R. Rep. No. 94-1656, 94th Cong., 2d Sess. 3, 4-5, 11 (1976).

c. Respondent also relies (Resp. Br. 13) upon the statement in *United States* v. *Testan* that the existence of a right of action against the United States for money damages depends on whether the particular federal statute cited " 'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained.' " (424 U.S. at 400, quoting *Eastport Steamship Corp.* v. *United States*, 372 F. 2d 1002, 1009 (Ct. Cl. 1967)). Respondent seeks to bring the instant case within this language by

asserting that "medicare legislation, fairly read, mandates appropriate payment to providers" (Resp. Br. 14),[1] apparently because the Medicare program establishes a system for the *administrative* reimbursement of medical expenses incurred by Part B beneficiaries (see Resp. Br. 19-22). From this, respondent argues that the appropriate inquiry in this case is whether "Congress has carved out * * * an exception to that general grant of jurisdiction and waiver of sovereign immunity" (Resp. Br. 22; see also *id.* at 14, 21-22, 26-28; Br. in Opp. 6-7). Once again, respondent has it backwards. Neither the Tucker Act nor any other statute passed by Congress contains a general waiver of the sovereign immunity of the United States to suits for money damages, from which it would have been necessary for Congress to except Medicare claims. Rather, it is necessary to inquire in each case whether the specific statute upon which the claimant relies—here, the Medicare Act—contains an affirmative waiver of the United States' sovereign immunity to such suits.

Alternatively, respondent appears to argue that a specific waiver of sovereign immunity to suit is inherent in the Medicare Act's provision for the payment of monetary benefits under Part B and that this waiver must be given

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[1] Here and at several other places in its brief (Resp. Br. 3, 15-17, 19, 20, 21), respondent appears to suggest that it has rights as a "provider of services" that are distinct from those of the individual Part B beneficiaries from whom it has accepted assignments of reimbursement claims. This is incorrect. Respondent is not a "provider of services" for purposes of the Act. That term is defined as a hospital, skilled nursing facility, home health agency, or fund. 42 U.S.C. 1395x(u). Such "providers" are reimbursed directly for their services covered by Part A and Part B, and they have distinct statutory rights of review in some circumstances. See, *e.g.*, 42 U.S.C. 1395ff(c), 1395*oo* and 1395pp(d). Respondent, however, like physicians and other furnishers of Part B services, possesses only the procedural rights of the beneficiaries from whom it has accepted assignments. 42 C.F.R. 405.801(a); *Kechijian* v. *Califano*, 621 F. 2d 1, 4 n.4 (1st Cir. 1980); *Szekely* v. *Florida Medical Association*, 517 F. 2d 345 (5th Cir. 1975), cert. denied, 425 U.S. 960 (1976).

effect unless Congress, in enacting Part B, has carved out an exception to the waiver. See Resp. Br. 10-11, 19-21, 23. This argument, however, reduces to the suggestion that the appropriate inquiry is whether Congress, in the same part of the same statute, has engaged in the rather absurd exercise of simultaneously giving and taking away the right to sue the United States. This obviously is not the test. There is but a single ultimate question that determines the jurisdictional issue in this case: whether Part B of the Medicare Act contains the requisite "unequivocally expressed" waiver of sovereign immunity.

In any event, the premise of respondent's argument that a waiver of sovereign immunity is inherent in Part B of the Medicare Act is erroneous. The issue presented concerns the United States' immunity from *suit*, not an "immunity," as such, to the disbursement of money. Accordingly, contrary to respondent's apparent belief, the mere fact that Congress has provided for the distribution of monetary benefits administratively through private insurance carriers does not mean that Congress has thereby consented to be sued every time a beneficiary or his assignee alleges that the carrier has erred in calculating the amount of money to be paid administratively. See, *e.g.*, *Johnson* v. *Robison*, *supra*. Resolution of the sovereign immunity issue requires an analysis of the Part B program in its entirety, including the relatively small amount of money involved in the typical Part B claim, the vast number of Part B beneficiaries (more than 27 million) and individual claims they file (more than 150 million annually), and the provision for administration of the Part B program by private insurance carriers without review by the Secretary. These factors weigh heavily against concluding that Congress intended to subject the United States to the expense and burden of suits on individual Part B benefit claims. Weighing even more heavily against this conclusion, however, are the text and legislative history of Part B, to which we now turn.

2.a. Respondent concedes (Resp. Br. 23-25) that Congress granted the beneficiary a right to judicial review under Part A with respect to both the individual's eligibility to participate in the Part A program generally and the amount (if any) of benefits payable for particular services, but granted a right to judicial review under Part B only with respect to the individual's right to participate in the program. 42 U.S.C. 1395ff(b). As we explained in our opening brief (U.S. Br. 23-24), this strongly indicates that Congress intended to foreclose judicial review of the amount of benefits payable under Part B. Respondent points out, however, that 42 U.S.C. 1395ff(b) confers a right to judicial review on matters for which there is a right to a prior hearing by the Secretary; benefit determinations under Part B, in contrast, are made by private insurance carriers pursuant to a different section, 42 U.S.C. 1395u(b)(3)(C). Because administrative review of Part B benefit determinations is dealt with elsewhere, respondent argues that the failure of Congress to provide for a right to judicial review of such determinations in 42 U.S.C. 1395ff(b) is not significant. The difficulty with this argument is that Congress likewise did not afford a right to judicial review of Part B benefit amount determinations in 42 U.S.C. 1395u(b)(3)(C). The fact that Congress expressly provided for judicial review of Part A claims but did not so provide for Part B claims in *either* of the relevant sections plainly indicates a congressional intent to foreclose judicial review under Part B.

The significance of Congress' failure affirmatively to provide for judicial review under Part B when it did so under Part A is underscored by 42 U.S.C. 405(h). That Section, which is incorporated into the Medicare program through 42 U.S.C. 1395ii, states that no findings of fact or decision of the Secretary shall be reviewed by any "tribunal," except as provided in the Medicare Act itself. Because carriers act as agents of the Secretary in reviewing Part B

claims, this express preclusion of judicial review in Section 405(h) necessarily applies to Part B benefit determinations and is sufficient to foreclose Tucker Act jurisdiction in this case without resort to the legislative history. *Lehman* v. *Nakshian*, No. 80-242 (June 26, 1981), slip op. 9. Indeed, the third sentence of Section 405(h), which specifically addresses the jurisdiction of the district courts, expressly forecloses those courts from exercising their concurrent jurisdiction under the Tucker Act over Medicare claims. See U.S. Br. 42-43. Moreover, the legislative history, which respondent largely ignores, strongly reinforces the import of the statutory provisions just cited.

b. Respondent acknowledges (Resp. Br. 25-26) the passage in the Senate report on the 1965 Act which states that under Part B, "carriers, not the Secretary, would review beneficiary complaints regarding the amount of benefits" and that "the bill does not provide for judicial review of a determination concerning the amount of benefits under Part B where claims will probably be for substantially smaller amounts than under Part A" (S. Rep. No. 404, 89th Cong., 1st Sess. 54-55 (1965)). But respondent maintains (Resp. Br. 26) that this passage merely indicates that Congress was "deliberately silent" on the question of judicial review under Part B. Of course, congressional silence, if that were all that is involved here, would alone be sufficient to bar a suit for money damages against the United States. However, Congress was not "deliberately silent" on the question; it deliberately foreclosed judicial review of Part B benefit determinations.

Like the Court of Claims (Pet. App. 13a), respondent has quoted selectively from the passage in the 1965 Senate report, which is quoted in full in our opening brief (U.S. Br. 27-28). In the sentence immediately preceding that quoted by respondent, the report points out that administrative *and* judicial review are available under Part A--in contrast

to Part B, discussed in the sentence respondent quotes. In the last sentence of the passage, the report then states: "*It is intended that the remedies provided by these review procedures shall be exclusive.*" This sentence makes clear that the procedure for pursuing Part B claims—review by the carrier (rather than the Secretary), without the right to subsequent judicial review available under Part A—was intended to be "exclusive."

Respondent also fails to mention, much less answer, the discussion in our opening brief (U.S. Br. 28-30) of the 1972 amendments to 42 U.S.C. 1395ff. Prior to 1972, that Section had been interpreted to permit judicial review of an individual's "entitlement" to receive any payment for particular services under Part B, but not the amount of payment due. *Bohlen* v. *Richardson*, 345 F. Supp. 124 (E.D. Pa. 1972), aff'd, 483 F. 2d 918 (3d Cir. 1973). Congress closed this unintended loophole by amending 42 U.S.C. 1395ff to read as it now does, subsuming questions of entitlement in the question of the amount (if any) of benefits due in a particular case. See U.S. Br. 29 & n.27; 42 U.S.C. 1395ff(b)(1)(C). Congress emphasized in the Conference Report that these amendments were intended to make clear that "*there is no authorization * * * for judicial review on matters solely involving amounts of benefits under Part B*" (H.R. Conf. Rep. No. 92-1605, 92d Cong., 2d Sess. 61 (1972) (emphasis added)).

Respondent suggests (Resp. Br. 26), however, that the import of the legislative history is that judicial review is barred only of the carrier's calculation of the *amount* payable for particular services, not of all statutory questions that might have an effect on benefit determinations. But these are not two distinct categories of cases, as respondent suggests. Respondent's own challenge, for example, is to Prudential's computation of the amount payable on respondent's assigned claims. Indeed, unless a beneficiary or his

assignee sought greater reimbursement, he presumably would not bother to file suit at all. Moreover, respondent has pointed to nothing indicating a congressional intent to draw a distinction between challenges to the amount of reimbursement that are based on the statute and challenges that are based on some other ground. To the contrary, the 1972 amendments foreclosing judicial review on questions of statutory "entitlement" to receive at least same payment for particular services in a given case and subsuming such questions in the determination of the amount (if any) of payment due make abundantly clear that Congress did not intend that any such distinction should be drawn for purposes of judicial review. Finally, the vast majority of claimants no doubt would be capable of withstanding a motion to dismiss by drafting an artful pleading that contests the carrier's determination as being in violation of the statute or implementing HHS regulations. Respondent's suggested approach therefore would foster litigation over the threshold question whether the particular issue involved is exempt from or subject to judicial review, and, as a result, it would frustrate the evident congressional purpose to foreclose litigation.

3. Apparently recognizing the weakness of its argument that the Medicare Act itself creates a right to sue the United States for money damages, respondent now seeks to attain the same result indirectly by arguing (Resp. Br. 14-19) that the Medicare statute establishes certain contractual relationships that in turn may be enforced by respondent's suit for money damages.[2] This basis of jurisdiction was not asserted in respondent's petition or supplemental petition in the Court of Claims and was not considered by that court. It

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[2]The Tucker Act confers jurisdiction on the Court of Claims to render judgment upon any claim against the United States founded "upon any express or implied contract with the United States * * *." 28 U.S.C. 1491.

therefore need not be considered here. In any event, respondent's contract claim is wholly without merit.

Respondent first contends (Resp. Br. 14-17) that a Medicare Part B beneficiary has a contract with the United States for the payment of benefits and that, as assignee, respondent may sue for breach of that contract. Respondent concedes there is no express contract, but argues that one may be implied in fact. However, Congress enacted the Medicare program as Title XVIII of the Social Security Act, and this Court has made clear that benefits under the Social Security Act are not contractual in nature. *Weinberger* v. *Salfi*, 422 U.S. 749, 771-772 (1975); *Flemming* v. *Nestor*, 363 U.S. 603, 608-611 (1960); cf. *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 174 (1980).

Moreover, a contract implied in fact is an agreement "founded upon a meeting of minds, which, although not embodied in an express contract, is inferred, as a fact, from the conduct of the parties showing, in the light of the surrounding circumstances, their tacit understanding." *Baltimore & O.R.R.* v. *United States*, 261 U.S. 592, 597 (1923). Respondent did not allege, much less prove, any unique facts surrounding the relationships between the Secretary and the numerous individual Part B beneficiaries from whom it has accepted assignments that would suggest a meeting of the minds and the existence of implied-in-fact contracts between them.[3] It relies instead (Resp. Br. 15) on the terms of the Medicare statute alone, contending that the United States has "offered" in that statute to provide a supplemental insurance program and beneficiaries have "accepted" that offer by voluntarily enrolling in the program. As an initial matter, respondent overlooks the fact

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[3]In contrast, such particularized facts were alleged in *Fox* v. *Harris*, 488 F. Supp. 488, 492 (D.D.C. 1980), the only Medicare case respondent cites in support of its contract argument. *Harris* is discussed in our reply brief at the petition stage (at 7 n.4).

that persons who are enrolled in the Part A Medicare program are automatically enrolled under Part B unless they withdraw from coverage. 42 U.S.C. 1395p(f) and 1395q(b). Thus, there is no occasion for a particularized meeting of the minds between the Secretary and the individual upon the latter's enrollment under Part B. In addition, respondent's argument presumably would lead to the finding of a contractual relationship between the Secretary and all 27 million beneficiaries under Part B, a truly startling result to reach by mere "implication."

In any event, the contract that respondent suggests is created by nothing more than the terms of the Medicare statute itself would not be an implied-in-fact contract, but would be one implied in law, or a quasi-contract—"an obligation that is created by the law without regard to expressions of assent by either words or acts." 1 A. Corbin *Contracts* § 19, at 44 (1963). It is well settled that the Tucker Act does not confer jurisdiction over claims arising under quasi-contracts or contracts implied in law. *Hatzlachh Supply Co.* v. *United States*, 444 U.S. 460, 465 n.5 (1980); *United States* v. *Algoma Lumber Co.*, 305 U.S. 415, 418 (1939); *Merritt* v. *United States*, 267 U.S. 338, 341 (1925).[4] Finally, even if the terms of the Medicare statute itself could be said to create contracts between the Secretary and each of the 27 million individual Medicare beneficiaries, one of the statutory terms included in those contracts necessarily would be the statutory preclusion, discussed above, of a right to sue the United States to recover on a claim denied by a Part B carrier.

For similar reasons, respondent errs in contending that, although the Medicare Act itself confers no right to sue the

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[4]See generally the government's brief in *Army and Air Force Exchange Service* v. *Sheehan*, No. 80-1437 (to be argued Feb. 23, 1982), at 22-25. We have furnished respondent with copies of the government's briefs in *Sheehan*.

United States, this deliberate omission can be circumvented simply by characterizing the 27 million Medicare beneficiaries and their assignees as third party beneficiaries who may sue to enforce the provision of the contracts between the Secretary and the carriers under which the carriers are obligated to determine and pay Part B benefits. The terms of the contract between the carrier and the Secretary upon which respondent relies (Resp. Br. 18-19) are in fact provisions of the statute, 42 U.S.C. 1395u, not any particular provisions of the actual contract between Prudential and the Secretary.[5] Thus, respondent's third party beneficiary argument is but another way of saying that the Medicare Act affirmatively grants the beneficiaries a right to sue the United States for money damages, an argument that must be rejected for the reasons given above.

4. Finally, respondent argues (Resp. Br. 28-33) that serious constitutional questions would be presented if the Medicare Act were construed to bar judicial review in all situations, even where constitutional questions are raised, and that the Act therefore should be construed to allow judicial review. This argument is entirely misplaced in the context of the present case.

This case concerns only the jurisdiction of the Court of Claims under the Tucker Act. It is well-settled that the Tucker Act does not confer jurisdiction over cases seeking money damages for alleged violations of the Due Process

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[5]Moreover, respondent has not sued Prudential, the party that allegedly has breached the contract; it has sued the United States. Of course, respondent could not sue Prudential in these circumstances either. See U.S. Br. 27 n.24. See also *Mitchell* v. *Occidental Insurance, Medicare*, 619 F. 2d 28, 30 (9th Cir. 1980); *Matranga* v. *Travelers Insurance Co.*, 563 F. 2d 677 (5th Cir. 1977); *Pine View Gardens, Inc.* v. *Mutual of Omaha Insurance Co.*, 485 F. 2d 1073, 1075 (D.C. Cir. 1973).

Clause,[6] the constitutional violations respondent alleged here, because that Clause does not mandate the payment of compensation for a violation. See *United States* v. *Testan, supra*, 424 U.S. at 400; *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976); *Alabama Hospital Association* v. *United States*, 656 F. 2d 606, 609 (Ct. Cl. 1981), petition for cert. pending, No. 81-875. Moreover, even if the Court were to construe the Medicare Act to permit judicial review of certain constitutional issues in order to avoid the constitutional question that might be raised by a complete bar to such review, this would afford no basis for also construing the Act, as respondent urges, to authorize suits against the United States to the extent they raise purely statutory issues. Cf. *Califano* v. *Sanders*, 430 U.S. 99, 108-109 (1977).

For the foregoing reasons and the additional reasons stated in our opening brief, it is respectfully submitted that the judgment of the Court of Claims should be vacated and the case remanded with directions to dismiss for lack of jurisdiction.

REX E. LEE
Solicitor General

FEBRUARY 1982

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[6]Respondent also alleged a violation of the Just Compensation Clause (Resp. Br. 6-7 n.5), for which the Tucker Act does provide jurisdiction (see *United States* v. *Testan, supra*, 424 U.S. at 401), but the just compensation issue is not involved in this case. See U.S. Br. 11 n.13.

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No. 80-1594

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1980

UNITED STATES of AMERICA, PETITIONER

-VS-

ERIKA, INC.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS

BRIEF OF AMICUS CURIAE IN SUPPORT OF RESPONDENT

AMERICAN ACADEMY OF FAMILY PHYSICIANS

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QUESTION PRESENTED

DOES THE COURT OF CLAIMS HAVE JURISDICTION UNDER 28 U.S.C. (& Supp. III) § 1941 TO REVIEW DECISIONS MADE BY A PRIVATE INSURANCE CARRIER CHARGED WITH THE ADMINISTRATION FOR PART B OF THE MEDICARE ACT, 42 U.S.C. (& Supp. III) § 1395, *ET SEQ*?

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II. INTEREST OF AMICUS CURIAE

American Academy of Family Physicians (hereinafter Amicus Curiae) is a non-profit professional association consisting of approximately 40,000 family physicians. Amicus Curiae members are physicians educated and trained to develop and exercise, through their practice, an approach and skills which qualify members to provide continuing, comprehensive health care to an entire family, regardless of sex, age, or medical ailment. Amicus Curiae is keenly interested in the delivery of health care, including the various effects that the administration of the Medicare Program may have upon the delivery of health care to the family. Amicus Curiae's general goal is to foster the delivery of primary health, and to this end, Amicus Curiae encourages individuals entering the medical field to specialize in primary care and engages in other projects toward fostering quality primary care.

Amicus Curiae believes that the decision currently before this Court is exceedingly important to the efficient and fair delivery of health care in this country. At issue is the availability of a competent and fair forum to bring grievances concerning the manner by which a major social program—the Medicare Act—is administered. It is Amicus Curiae's position that to reverse the Court of Claims in this case by accepting the arguments made by petitioner would have ramifications outside the limited question concerning jurisdiction of the Court of Claims. Petitioner's argument, if accepted by this Court, would foreclose jurisdiction not only as exercised by the Court of Claims, but other federal courts as well.

While the constituent members of Amicus Curiae are each generally concerned and involved with the Medicare Program, they have no vested or monetary interest in the exact outcome of this case. As a result, Amicus Curiae believes that it is particularly well suited to present a balanced, fair view of the jurisdictional question before this Court. If an objective appraisal of the pertinent statutes is

to be forthcoming and if a balance between competing interests is to be struck, Amicus Curiae believes it can assist this Court in reaching a resolution which will be in the best interests of this country's citizenry and their health. Amicus Curiae hopes to provide this Court with an overview of the issues raised and the way in which this Court's resolution will impact upon the delivery of health care.

III. OVERVIEW OF MEDICARE PROGRAM

The Medicare Program (Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq*) is a statutory labyrinth[1] which assures federal payment for a portion of certain medical expenses incurred by persons 65 years of age, or other persons entitled to Social Security benefits.[2] The Secretary of Health, Education and Welfare[3] (hereinafter "Secretary") is given the executive responsibility for administering the Program. Although explained more fully, *infra*, the Secretary is empowered to delegate and has delegated the administration of the Program to private insurance entities.

The Medicare Program consists of two subprograms. Part A of the Program, 42 U.S.C. § 1395c-1395i[4] is a hospital insurance program, whereas, Part B, § 1395i-1395w, is a voluntary, supplemental insurance

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[1] It would seem appropriate to issue a caveat to any court which is about to entertain arguments concerning the interpretation of the Medicare or Medicaid Acts (Titles XVIII and XIX of the Social Security Act, 42 U.S.C. § 1395 *et seq* and § 1396 *et seq*). The warning is perhaps best issued by repeating what jurists have already said about the language these statutes employ. Judge Friendly noted that the Act was "almost unintelligible to the uninitiated", *Friedman* v *Berger*, 547 F 2d 722, 727 n. 7 (2nd Cir 1976) *cert den* 430 U.S. 984 (1977). The District Court in *Friedman* v *Berger*, 409 F Supp 1225 (S.D. N.Y. 1976), described the Act as "an aggravated assault on the English language", and Justice Powell indicated that the Act was "among the most intricate ever drafted by Congress" and had a "byzantine construction." *Schweiker* v *Gray Panthers*, U.S. ; 101 S.Ct. 2633; 69 L. Ed. 2d 460 (1981).

[2] The size of the Program is truly staggering. Recent figures submitted to Congress indicate that 29,331,000,000 Federal dollars were spent on the Medicare Program in 1980. *Impact of Fiscal Year 1982 Budget Cuts on the Elderly: Hearing before the Select Committee on Aging, House of Representatives*, 97th Cong., 1st Sess., April 6, 1981, p 30.

[3] In keeping with the decision rendered by the Court of Claims, reference will be made to the Department of Health, Education and Welfare rather than the Department's new name, Department of Health and Human Services.

[4] All Section references hereafter will be to 42 U.S.C. unless otherwise indicated.

program covering the costs of other medical care. Since the current case arises under Part B, this Court can focus its attention to this subpart. However, the distinction between the subprograms is discussed, *infra*.

Under Part B, Medicare pays supplemental providers, such as individual physicians, or x-ray or diagnostic laboratories, on a "reasonable charge" basis.[5] Those otherwise entitled to Social Security benefits have a deduction taken from their benefits to help cover the cost of the Part B Program. The money so deducted is channeled into the Supplemental Medical Insurance Trust Fund, § 1395t. The monies contained in the Fund are then used to pay Part B benefits and help cover the cost of administering the Program. The Secretary is authorized to enter into contracts with private entities, or "carriers," for the administration of Part B. Said carriers become responsible for (1) making determinations as to rates and payments; (2) receiving, disbursing and accounting for funds; and (3) conducting audits to assure proper payment, § 1395u.

A beneficiary is entitled to a hearing by the Secretary when a challenge to the beneficiary's eligibility to enroll in the Program is made [§ 1395ff(b)(1)(B)]. The Secretary is further empowered to enter into contracts with carriers and the contract is to provide for a "fair hearing by the carrier" if the amount in controversy is $100.00 or more and a challenge of the following types are made: (1) payment for services furnished are denied; (2) payment is not made with reasonable promptness; or (3) payment for a given service is in controversy. [§ 1395u(b)(3)(C)]. However, there is no provision in the Medicare Act which either expressly grants or expressly denies review to a beneficiary or provider for

[5] Part B reimbursement consists of 80% of the "reasonable charge" and "reasonable charge" is the lowest of the actual charge, customary charge or prevailing charge. Consequently, Part B reimbursement is always less than what the provider's actual fee is for a particular service. § 13951.

other types of claims or challenges. From this absence of any explicit statutory provision, the current dispute surrounding statutory construction arises.

It is also beneficial that this Court appreciate the normal practices surrounding disbursement of funds under Medicare. The Medicare Act—Part B—provides two methods for the disbursement of funds. Under the first method, the eligible recipient of funds obtains treatment from a provider, pays the provider directly, and submits a request for payment to the carrier.

Under the second method, patients assign their claims for Medicare benefits to the provider who performed the particular services. The provider then submits all assigned claims to the carrier. It is important for the Court to appreciate the prevalence of the assignment method and the effect this has upon the Program.[6]

The Petitioner paints an unrealistic portrait of the Part B Program to the extent that Part B is characterized by the submission of the multitude of small claims. The reality of the Program is that providers have accepted the majority of claims and are requesting payment from the carrier in relatively large amounts equalling the requests made by Part A providers.

The number of assigned claims is important to appreciate, since it groups claims in a way not necessarily predictable from a perusal of the Act. A provider requesting payment for a large number of claims covering a wide range of services has a wider exposure on how the Program is

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[6] In 1966 two out of three Medicare claims were assigned. The rate of assignment has been dwindling, but is still over 50%. *Medicare after 15 Years: Has It Become a Broken Promise to the Elderly?:* Report by Select Committee on Aging, U.S. House of Representatives, 96th Cong., 2nd Sess., November 17, 1980, p 12. See also Ferry, *Physicians Changes Under Medicare: Assignment Rates and Beneficiary Liability*, Health Care Financing Review, Winter 1980.

generally administered and is more likely to be cognizant of when the Program is being administered unreasonably or illegally.[7]

[7] One indication of this fact is that the cases which have arisen under Part B are generally provider cases, as opposed to beneficiary cases. Despite petitioner's contention that allowing Part B claims a federal judicial forum would inundate the federal courts, petitioner's Brief cites only one Part B case which has been brought by a Medicare beneficiary [*Kuenstler* v *Occidental Life Insurance Co.*, 292 F Supp 532, (C.D. Cal. 1968)]. The simple fact is that it would usually be economically unsound for beneficiaries to pursue a claim concerning a given medical service in Federal Court, since the claim would in most cases, be less than the cost of litigation.

IV. ARGUMENT

NEITHER THE MEDICARE ACT NOR PROVISIONS OF THE SOCIAL SECURITY ACT INCORPORATED INTO THE MEDICARE ACT EVIDENCE CLEAR AND CONVINCING LEGISLATIVE INTENT TO BAR JUDICIAL REVIEW OF ALL CARRIER DETERMINATIONS CONCERNING MEDICARE PART B BENEFITS.

An appropriate starting point in the case at bar is to recognize which party bears the burden of demonstrating legislative intent as it relates to the disputed statutes. In reviewing the Brief submitted by petitioner, one is tempted to conclude that it is Respondent's burden to convince this Court that the pertinent provisions of the Medicare Act explicitly grant federal court jurisdiction to Respondent. Petitioner would seemingly ignore the general rule that any interpretation of a statute dealing with review of administrative decisions that fails to provide for administrative *and* judicial review is suspect unless clear and convincing evidence of a congressional intent to foreclose such review is present. *Abbott Laboratories* v *Gardner*, 387 U.S. 136 (1967); *Rusk* v *Court*, 396 U.S. 367 (1967); *Citizens to Preserve Overton Park, Inc.* v *Volpe*, 401 U.S. 402 (1971); *Dunlap* v *Bachowski*, 421 U.S. 560 (1975); *Califano* v *Sanders*, 430 U.S. 99 (1977).

Petitioner recognizes the presumption in favor of judicial review but argues that the presumption is "reversed" when the pertinent statutes and history are reviewed (Pet. Br., p 37). Obviously, the presumption is not "reversed"; the question becomes whether the presumption is overcome by a clear and convincing showing of intent to foreclose judicial review. It is petitioner's burden to overcome the presumption by persuading this Court that the Court of Claims' decision was erroneous and that the pertinent statutory provisions show an affirmative intent to deprive Part B providers, or beneficiaries, of a judicial forum.

Petitioner's attempt at showing legislative intent by clear and convincing evidence relies upon an analysis of the Medicare Act itself and certain passages from Congressional reports. It is the position of Amicus Curiae that a review of the Act and its history falls far short of showing by clear and convincing means that Congress intended to foreclose review of all Part B claims.

The only section of the Medicare Act which deals directly with review rights under Part B is § 1395ff.[8] A review of that statute, as set out below, indicates that a distinction is drawn between review under Part A and under Part B.

Pursuant to § 1395ff(b), an individual is entitled to a hearing by the Secretary (and judicial review thereafter) as to

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[8] This section currently provides in relevant part:

> (a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b) (1) Any individual dissatisfied with any determination under subsection (a) of this section as to—
>
> (A) whether he meets the conditions of section 426 or 426a of this title, or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of of this subchapter, or section 1395i-2 of this title or section 1819, or
>
> (C) the amount of benefits under Part A of this subchapter (including a determination where such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

determinations concerning: (1) whether the beneficiary is eligible to participate under Part A [§ 1395ff(b)(1)(A)]; (2) whether there is eligiblility to participate in Part B [§ 1395ff(b)(1)(B)]; and (3) the "amount of benefits" payable under Part A [§ 1395ff(b)(1)(C)].

Petitioner argues that this absence of any mention of review for a Part B benefit determination "affirmatively shows that Congress deliberately withheld judicial review of reimbursement claims under Part B." (Pet. Br., p. 23). The language of the staute shows only that Congress did not "affirmatively" say anything about Part B review other than that there was a right to review participation (eligibility) in Part B. Clearly, no more can be said of § 1395ff than it is silent as to review of Part B claims other than Program participation. To specifically *afford* review to certain individuals under one circumstance is hardly clear and convincing evidence that there is an intent to *foreclose* review to individuals in another set of circumstances. This Court faced a similar argument concerning congressional silence in *Abbott Laboratories, supra,* at 141.

> The Government relies on no explicit statutory authority for its argument that pre-enforcement review is unavailable but insists instead that because the statute includes a specific procedure for such review of certain enumerated kinds of regulations, not encompassing those of the kind involved here, other types were necessarily meant to be excluded from any pre-enforcement review. The issue, however, is not so readily resolved; we must go further and inquire whether in the context of the entire legislative scheme the existence of that circumscribed remedy evinces a congressional purpose to bar agency action not within its purview from judicial review. As a leading authority in this field has noted, "The mere fact that some acts are made reviewable should not suffice to support an implication of exclusion as to others. The right to

review is too important to be excluded on such slender indeterminate evidence of legislative intent." (footnote deleted)

Moreover, the fact that § 1395ff distinguishes between Part A and Part B in delineating review rights cannot be used as an indication that there was an intent to foreclose review under Part B. As petitioner notes, § 1395ff was rewritten in 1972 and § 1395oo was added. Petitioner argues that an intent to foreclose review can be gleaned from the fact that Congress, in amending the Medicare Act in 1972, specifically expanded the review rights under Part A, but left Part B unchanged. The history of review afforded under Part A does not lead to the conclusion that in expanding review under Part A, Congress intended to foreclose review under Part B.

One can start with the fact that prior to the 1972 amendments, the review afforded to providers in Part A and Part B services was quite similar, i.e., § 1395ff was silent as to whether challenges made by a provider to the amount of benefits for a given service could be reviewed under either subpart. Despite this Congressional silence, the federal courts held that judicial review was afforded under Part A. *Aquavella* v *Richardson*, 437 F 2d 397 (2nd Cir, 1971); *Maddox* v *Richardson*, 464 F 2d 617 (6th Cir, 1972); *Davis* v *Richardson*, 460 F 2d 772 (3rd Cir, 1972); *Rothman* v *Hospital Service of Southern California*, 510 F 2d 956 (9th Cir, 1975); *American Nursing Centers, Inc., et al* v *Weinberger, et al*, 387 F Supp 1116 (S.D. Ill. 1975); *South Boston General Hospital* v *Weinberger*, 397 F Supp (W.D. Vir., 1975). Giving this judicial finding of jurisdiction, the 1972 amendments cannot be accurately depicted as curing a jurisdictional defect in the Act. Congress, by way of the 1972 amendments was not affording review where it had not existed previously. Consequently, there cannot be inferred to Congress an intent to confer jurisdiction under one subpart (Part A) and deny jurisdiction in another subpart (Part B). Such an analysis fails in its first premise

since an historical look at the judicial interpretation prior to 1972 indicates that review was not foreclosed under the Act as originally drafted.[9]

One major contention of petitioner is that the legislative history of the Medicare Act indicates that *all* review of Part B cases (except Program eligibility) is to be foreclosed. A careful reading of the history cited by the Petitioner falls short of constituting clear and convincing evidence that Congress intended to foreclose regulatory, statutory or constitutional challenges to Part B program administration.

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[9] The history of review afforded under Part A after this Court's decision in *Weinberger* v *Salfi*, 422 U.S. 749 (1975), is also noteworthy. After the *Salfi* decision was rendered, the circuits took divergent approaches to whether judicial review was available for those Part A cases arising before the effective date of the 1972 amendments to the Medicare Act. The Court of Claims found jurisdiction as to questions of law and constitutional claims. *Whitecliff, Inc.* v *U.S.*, 536 F 2d 347 (Ct. Cl., 1976) *cert den* 430 U.S. 969 (1977). The Second, Fifth and Seventh Circuits concluded that § 405(h) was a bar to federal court jurisdiction, but then, interestingly transferred the cases under consideration to the Court of Claims so that the statutory and/or constitutional challengers would have a forum. See *South Windsor Convalescent Home, Inc.* v *Mathews*, 541 F 2d 910 (2nd Cir, 1976); *Dr. John T. MacDonald Foundation, Inc.* v *Califano*, 571 F 2d 328 (5th Cir, en banc, 1978) *cert den* 439 U.S. 893 (1978); *Trinity Memorial Hospital of Cudahy, Inc.* v *Associated Hospital Service, Inc.*, 570 F 2d 660 (7th Cir. 1977). The Sixth Circuit found judicial review available. *Chelsea Community Hospital* v *Michigan Blue Cross Association*, 630 F 2d 1131 (6th Cir, 1980). The Eighth Circuit found that 405(h) was a bar to certain claims, but could not bar constitutional challenges to the Act, or its administration. *St. Louis University* v *Blue Cross Hospital Service*, 537 F 2d 283 (8th Cir 1978) *cert den* 429 U.S. 977 (1976). The importance of reciting these cases is the fact that no circuit interpreted § 405(h) and the *Salfi* opinion in such a way as to deprive the parties before them of a federal, judicial forum for constitutional claims. As indicated, even those circuits which found § 405(h) a bar transferred the case under consideration to the Court of Claims. This history of Part A cases demonstrates the extreme position petitioner is advocating. Petitioner's position would foreclose *both* Part A (for cases arising under the Medicare Act and before the effective date of the 1972 amendments) and Part B cases raising constitutional issues. Such an extreme position was rejected by the circuits deciding Part A cases and should be similarly rejected by this Court.

As to the legislative history accompanying the original 1965 Act, the cited passage indicates that "this Bill does not provide for judicial review over determinations concerning the *amount of benefits* under Part B where claims will probably be for substantially smaller amounts than under Part A." S. Rep. No. 404, 89th Cong., 1st Sess. (1965) p 55. (Emphasis added)

Similarly, the passage quoted by petitioner concerning the 1972 Amendments states:

> The situations in which Medicare decisions are appealable to the courts were intended in the original law to be greatly restricted in order to avoid overloading the courts with quite minor matters. The law refers to "entitlement" as being an issue subject to court review and the word was intended to mean eligibility to any benefits of Medicare but not to decisions on a claim for *payment for a given service*. (118 Cong. Rec. 33992, 1972). (Emphasis added)

The Conference Committee stated:

> There is no authority for an appeal to the Secretary or for judicial review on matters solely involving *amount of benefits* under Part B. H.R. Conf. Rep. No. 92-1605, 92nd Cong. 2nd Session, p 61 (1972). (Emphasis added)

Clearly, in each of the three pieces of legislative history cited by petitioner, reference is made to foreclosing review of a carrier determination concerning "payment for a given service," i.e., "amount of benefits." Amicus Curiae believes the Court of Claims was correct in the case at bar when it reviewed this legislative history and concluded that:

> These statements do not constitute "clear and convincing" evidence . . . that Congress intended to bar judicial review of constitutional and statutory challenges to benefit determinations under Part B of Medicare. The fair import of these statements is that

> Congress intended to bar judicial review of the amount of particular benefit determination—as, for example, a carrier's determination that $50 rather than the $100 a physician charged was a reasonable amount for the services.

The Court of Claims' interpretation of the operative legislative history is supported not only by the language used by Congress in discussing the Medicare Act, as emphasized in the above passages, but also by the Medicare statutes and regulations.

Section 1395ff is a clear indication that Congress did afford different review rights to different sorts of challenges. As the previous analysis of § 1395ff indicates, a challenge to one's *eligibility to participate* in Part B is accorded a review by the Secretary, § 1395ff(b)(1)(B). This section further provides for review by the Secretary for Part A challenge based upon "amount of benefits." It will be recalled that this section is silent as to review concerning "amount of benefits" under Part B. Petitioner contrasts the of review for Part B amount-of-benefit challenges. It is Amicus Curiae's position that if the absence of review for Part B amount-of-benefit challenges is to be indicative of Congressional intent to foreclose review, it certainly can be extended no further than to foreclose this very sort of challenge.

The regulations concerning the hearing conducted by the carrier are also noteworthy on this point since the regulations delineate the types of challenges to be heard by the carrier. 42 C.F.R. 405.801 provides:

> (a) Section 1842(b)(3)(C) of the Act provides that a carrier shall establish and maintain procedures under which an individual enrolled in the supplemental medical insurance plan . . . is provided with the opportunity for a hearing by the carrier when the amount in controversy is $100 or more as determined in accordance with § 405.802(b) *and he is*

> *dissatisfied with the carrier's determination denying a request for payment, or with the amount of payment under the supplementary medical insurance plan or when he believes that the request for payment is not being acted upon with reasonable promptness.* (Emphasis added)

The fair hearing conducted by the carrier, as specified by § 1395u(b)(3), is controlled by regulations promulagated by the Secretary and by certain provisions of the "Carriers Manual."[10] See 42 C.F.R. 405.802—42 C.F.R. 405.872. After an "initial determination" (42 C.F.R. 405.807), a beneficiary or provider of services is given a right to a "fair hearing" (42 C.F.R. 405.820) conducted by a hearing officer designated by the carrier (42 C.F.R. 405.823). Pursuant to regulation (42 C.F.R. 405.824), the fact that the hearing officer is an employee of the carrier "may not serve as prima facia cause for disqualification." But see *McClure* v *Harris*, 503 F Supp 409 (C.D. Cal., 1980). The hearing officer is to preside over the hearing. Evidence may be received but need not be of a sort admissible in a court of law, 42 C.F.R. 405.830(b).

The jurisdiction of the hearing officer is carefully circumscribed by regulation:

> The hearing officer is exercising the authority to conduct a hearing under § 1842(b)(3)(C) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carriers. 42 C.F.R. 405.860.

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[10] The Carriers Manual is compiled by the Health Care Financing Administration. It's declared purpose is to serve as "the practical operating instructions needed by the contractors responsible for administration of the Supplementary Medical Insurance Program—Part B Medicare." (Forward to Carriers Manual).

The restrictions imposed upon the hearing officer's jurisdiction are made even more explicit by the Carriers Manual, a compilation of guidelines the hearing officer is required by the above regulation to follow. Section 12016 of the manual states:

> Authority—The HO occupies a significant position in the administrative appeals process affording dissatisfied individuals hearing rights as provided in § 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions and other guides issued by HCFA or the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare program.* (Emphasis added)

Even if one assumes that the Medicare statute's silence (when coupled with the legislative history and regulations cited) did intend to foreclose judicial review of Part B claims which challenge payment for a given service, petitioner paints with too broad of brush and would foreclose those claims not within the authority of the hearing officer to decide, i.e., regulatory, statutory or constitutional challenges to carrier determinations. Amicus Curiae respectfully submits that, at the most, the only challenges arguably foreclosed are those which the hearing officer had authority to act upon. Clearly, petitioner has failed to show by clear and convincing evidence an intent to foreclose challenges based upon a violation of a regulation, statute or constitutional right.

To this end, the Medicare Act, regulations promulgated by the Secretary, guidelines issued by the Health Care Financing Administration, and the legislative history are all consistent with one another. The Act provides for a "fair hearing" by the carrier as to claims which challenge the amount of payment for a given service (1395u). The Act is silent concerning judicial review for *this sort of challenge* (1395ff). Legislative history indicates that an "amount-of-benefits-for-a-given-service" challenge would most likely involve a multitude of small claims which could threaten to over-tax the limited resources of federal courts. The Secretary, and its constituent agency, the Health Care Financing Administration, in performing its delegated task of operating the Program and providing guidelines to carriers who administer the Program, interpreted the statute and history and formulated a hearing process to hear this sort of challenge, i.e., a challenge to the amount of benefit for a given service. In formulating the guidelines for this hearing process, the Secretary carefully limited the sorts of challenges which could be heard by the carrier's hearing officer and specifically *excluded* legal challenges based upon a violation of regulation, statute, or constitutional right. (See 42 C.F.R. 405.801 and Carriers Manual, as previously cited).

Simple logic dictates that the words "amount of benefits" be given a consistent reading. The regulations and Carriers Manual make clear that the Secretary has interpreted §1395u(b)(3)(C) and the language "amount of benefits" so as to preclude consideration of regulatory, statutory or constitutional claims from administrative process. Petitioner should not now be allowed to read the legislative history which seeks to foreclose judicial review over "amount of benefit" cases as to give these words a different meaning and foreclose regulatory, statutory and constitutional claims since these claims, pursuant to the Secretary's own interpretation, are not "amount of benefit" claims and cannot be administratively addressed by the carrier.

The distinction between what is and what is not an "amount of benefits" challenge has been clarified by the regulations and HCFA guidelines cited previously. It is a general rule of continuing validity that this Court defers to an administrative agency's interpretation of statutes they are delegated to execute. *Udall* v *Tallman*, 380 U.S. 1 (1965); *Batterton* v *Francis*, 432 U.S. 416 (1977); *Schweiker* v *Gray Panthers*, *supra*, a N 1. Experience teaches that the normal case to appear before a carrier hearing officer is one which challenges a decision of nonpayment for a given service or one which claims that the amount reimbursed was incorrect. Under the Act, reimbursement may be denied because the service was unnecessary or unreasonable for diagnosis or treatment, § 1395y(a)(1). Additionally, the precise amount reimbursed for a particular service is calculated through a complex formulae which considers the "prevailing charge," "customary charge," "actual charge," and "80th percentile of actual charge." See § 1395u(b)(3)(E). A challenge based upon these provisions of the Act would question certain medical determinations or arithmatic calculations. These stand in contrast to other claims which pose legal challenges to the Secretary's interpretation of the law or challenge the constitutionality of the law.[11]

Pursuant to the Program guidelines, the hearing officer at a Part B "fair hearing" is a "trier of fact." (Medicare Carriers Manual, § 12020). The hearing examiner need not be an attorney (Medicare Carriers Manual, § 12016 B). The three hearing officers for the carrier in Michigan, for example, are Marcia Lennox, Thomas Ruloff, and their supervisor, Clarence Bornheim. None of these individuals are attorneys. Both Mr. Ruloff and Ms. Lennox have previously been employees of carriers in Michigan involving the administration of the program. While clearly

[11] Examples of cases which have posed legal challenges (as opposed to factual "amount-of-benefit" challenges) are cited, *infra*.

experienced in "amount of benefit" controversies, a *legal* challenge is beyond the hearing officer's jurisdiction if not competency.

The case at bar clearly involves a legal and constitutional challenge to the carrier's determination. Respondent alleged that the carrier determined the benefits illegally, i.e., not in conformity with the applicable statutory and regulatory authority and additionally alleged certain constitutional violations. Since the determination of these challenges was beyond the carrier's authority, respondent is not foreclosed from seeking a federal court forum. In sum, there is no clear and convincing evidence that Congress intended respondent's regulatory, statutory or constitutional challenges foreclosed.

An attempt to buttress petitioner's argument is made by relying upon certain provisions incorporated into the Medicare Act pursuant to § 1395(ii). This section merely provides that:

> The provision of §§ 406 and 416(J) of this Title, and of subsections (a), (d), (e), (f), (h), (i), (k), and (l) of § 405 of this Title shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

Section 405(h) of the Social Security Act provides:

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under § 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

Section 405(g) of the Social Security Act provides:

> Any individual, after any final decision of the Secretary made after a hearing to which he was a part, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia.

It is petitioner's position that since § 405(h) was incorporated into the Medicare Act by § 1395ii and § 405(g) was not, Congress clearly intended to foreclose judicial review for all claims made under Part B.

The Medicare Act itself, §§ 1395ff and 1395oo, provides judicial review in certain instances. Petitioner's argument is, consequently, strung together with the following chain of inferences: Since 1395ii incorporated 405(h), but not 405(g), and since neither §§ 1395ff nor 1395oo explicitly provide for judicial review under Part B, Congress must have intended to foreclose review.

Whether or not § 405(h) is applied in a strict literal fashion or, as is dictated by § 1395ii, "to the same extent to which it is applicable to Title II of the Social Security Act," petitioner's reliance upon the incorporation of 405(h) is misplaced.

If a literal application is attempted, 405(h) bars judicial review of "the findings and decision of the Secretary after a hearing." Under Part B there is no hearing by the Secretary for the sort of claims made by respondent. Consequently, under a strict, literal interpretation, 405(h) is not applicable

to the Medicare Act. It is no rebuttal to content that the above interpretation would make §1395ii nugatory. Under Part A a hearing by the Secretary is conducted. Likewise, eligibility to participate in Part B is a claim reviewable by the Secretary. Therefore, § 405(h) would have application to the Medicare Act even if interpreted as above. Since respondent's claim is neither under Part A nor a question of eligibility to participate under Part B, a hearing by the Secretary is not conducted and § 405(h) preclusion of review is not applicable.

Secondly, § 405(h) precludes actions brought against the "United States, the Secretary, or any officer or employee thereof." A carrier under contract with the Secretary is neither an officer nor employee of the federal government.[12] Any legal action against the carrier, therefore, is not precluded by the language of § 405(h).

If one looks beyond the mere language of the statute and seeks to uncover the intent behind the incorporation of 405(h) into the Medicare Act, an identical result follows.

First, it should be noted that § 1395ii incorporated § 405(h) "only to the extent that [it is] applicable with respect to the 'Social Security Act." Section 405(h) does not apply to the Social Security Act so as to preclude all judicial review. Rather, § 405(g) provides for judicial review after the normal channels of administrative review have been exhausted. This was extensively discussed by this Court in *Weinberger* v *Salfi*, 422 US 749 (1975). This Court discussed the review provision of Title II of the Social Security Act and read § 405(h) as precluding original

[12] *Petitioner's argument has a basic inconsistency. First petitioner argues that there is a meaningful distinction to be found between those challenges which can be brought to hearing before the Secretary and those brought before the carrier. Since judicial review after a Secretary hearing is explicitly provided, the absence of a provision for review after a carrier hearing is relevant, so argues petitioner, since it indicates that judicial review was not intended. When the focus turns to the application of § 405(h), petitioner then argues that there is no distinction between a hearing by the Secretary and a hearing by the carrier.*

jurisdiction in Federal District Court pursuant to 28 USC§1331. However, this Court concluded that § 405(h) precluded original jurisdiction under 28 USC § 1331 since "the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions." *Weinberger* v *Salfi, supra,* 422 US at 762. Petitioner's interpretation would apply § 405(h) in a manner foreign to its application in cases arising under the Social Security Act. Under petitioner's interpretation, § 405(h), while not foreclosing all judicial review under the Social Security Act, would be foreclosing judicial review under Title II, would be foreclosing judicial review of important regulatory, statutory and constitutional claims under the Medicare Act.

Secondly, the terms of § 405(h) preclude review of determinations made by the "Secretary." As previously indicated, respondent (or any other Part B provider) is not given a hearing by the Secretary, but rather by the carrier: the private insurance entity delegated the responsibility of administering the Medicare Program.[13] The difference between a hearing by the carrier and a hearing by the Secretary has been previously discussed. The jurisdiction of the Secretary when conducting a hearing under Title II of the Social Security Act is not limited to determining only the correct benefit amount. Accordingly, the provisions of 405(h) which foreclose review under Title II cannot also foreclose review under Title XVIII since review is to be foreclosed pursuant to § 1395ii only "as applied" to Title II.

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[13] Petitioner contends it would be unreasonable to interpret these statutes so as to afford judicial review from a carrier hearing, thus exposing the government to liability due to carrier error. (Pet Br, p 26). However, petitioner's argument is answered by merely referring to another section of petitioner's brief which recognizes the carrier's special expertise (because of their private insurance business) to determine reasonable change and administer Part B (Pet Br, p 22). Amicus Curiae also questions the logic by which petitioner contends that commission of errors by the carrier is reason for foreclosing judicial review. If a carrier makes a regulatory, statutory or constitutional error in administering a program involving federal funds then those errors should be rectified. Certainly, the Secretary can't argue that those errors should not be corrected merely because it has delegated the decision-making process to a private entity.

B. IF CLEAR AND CONVINCING EVIDENCE TO FORECLOSE ALL REVIEW FOR ALL PART B CLAIMS IS ESTABLSIHED THE MEDICARE STATUTE (42 USC § 1395ff) WOULD BE AN UNCONSTITUTIONAL DENIAL OF DUE PROCESS.

Petitioner's Brief is a creative attempt at statutory construction but sadly relegates the U.S. Constitution to footnote status (see Pet Br, nts, 13, 39). It is Amicus Curiae's position that the principle of due process is keenly intertwined with the issue presented in the case at bar.

The inquiry into Congressional power to restrict the jurisdiction of the inferior federal courts has a long history with this Court. *Ex Parte McCardle*, 7 Wall. 506, 19 L. Ed. 264 (U.S., 1869); *United States* v *Klein*, 13 Wall. 128 (U.S. 1872). While commentators have taken different views concerning the extent of Congressional power in the area,[14] the fact remains that the foreclosure of jurisdiction to hear constitutional claims has been looked at with ascance by this Court. *Crowell* v *Benson*, 285 U.S. 22 (1932), *St. Joseph Stock Yards Co.* v *United States*, 298 U.S. 38, (1936).

It is only elementary to appreciate that constitutional principles play upon a case such as this on two levels. The first level concerns jurisdiction and unquestionably involves careful statutory construction but also includes the principle of due process. It is an inquiry into whether a court is empowered to even consider a case. The second level concerns the substantive merits of a claim when those merits are based upon constitutional rights. Petitioner's Brief suggests this Court need not be concerned with either level of constitutional analysis since the lower court found the substantive merits of respondent's constitutional claim

[14] Jaffe, *Judicial Control of Administrative Action*, 376-94 (1965); K. Davis, *Administrative Law in the Seventies*, § 2809 (1976); P. Bator, P. Miskin, D. Shapiro and H. Wechstler, *The Federal Courts and the Federal System, Note on Power of Congress to Limit the Jurisdiction of Federal Courts*, 313-375 (2d Ed. 1973).

lacking. Petitioner would seemingly ignore the whole first level of analysis. The Court of Claims concluded that it had jurisdiction and then went on to discuss the substantive merits of respondent's constitutional claims. The fact that the Court of Claims found those claims to be without merit does not mean that the presence of respondent's constitutional claims need not be considered. It is only after jurisdiction is accepted that substance is considered. The gravamen of the present case concerns not the merits of respondent's constitutional claims, but rather, respondent's ability to find a forum in which to assert those constitutional claims. This, however, is a consideration which brings the Constitution into play on the first level.

It is Amicus Curiae's position that any construction of the pertinent statutes which precludes judicial review of regulatory, statutory or constitutional challenges to the administration of the Medicare Act would be to invalidate the relevant provisions of the Act as constituting an unconstitutional denial of due process.

In *Johnson* v *Robison*, 415 U.S. 361 (1974), this Court was engaged in a task similar to the one currently undertaken. A statute made certain administrative determinations final and conclusive. However, when faced with a claimant who made substantive constitutional claims, this Court refused to give the statute its literal effect since to do so would have denied claimant a forum to voice constitutional challenges. The Court stated:

> Plainly, no explicit provision of § 211(a) bars judicial consideration of appellee's constitutional claims. That section provides that "the decision of the Administrator on any question of law or fact under any law administered by the Veterans Administration providing benefits for veterans . . . shall be final and conclusive and no . . . court of the United States shall have power or jurisdiction to review any such decision . . ." The

> prohibitions would appear to be aimed at review only of those decisions of law or fact that arise in the *administration* by the Veterans Administration of a statute providing benefits for veterans. A decision of law or fact "under" a statute is made by the Administrator in the interpretation or application of a particular provision of the statute to a particular set of facts, Appellee's constitutional challenge is not to any such decision of the *Administrator*, but rather to a decision of *Congress* to create a statutory class entitled to benefits that does not include I-O conscientious objectors who performed alternative civilian service. Thus, as the District Court stated: "The questions of law presented in these proceedings arise under the Constitution, not under the statute whose validity is challenged." (Emphasis in original) *Johnson* v *Robison, supra*, at 367.

Accordingly, this Court refused to apply the disputed statute so as to preclude judicial review of constitutional claims since "[s]uch a construction would, of course, raise serious constitutional questions concerning the constitutionality of [the disputed statute]." *Johnson* v *Robison*, supra, at 366.

Petitioner relies upon this Court's more recent decision in *Weinberger* v *Salfi, supra*, wherein this Court specifically considered the effect § 405(h) has upon judicial review. In *Weinberger* v *Salfi, supra*, a widow applied for Social Security insurance benefits for her daughter by a previous marriage. Her application was denied since her second husband died before her daughter could qualify as the child of her second husband. The Court held that jurisdiction pursuant to 28 U.S.C. § 1331 was barred by the third sentence of § 405(h). However, the *Salfi* decision does not lead to the conclusion that § 405(h) bars jurisdiction in the case at bar pursuant to 28 U.S.C. 1491. In *Salfi*, this Court carefully distinguished the earlier opinion in *Johnson* v *Robison*, by noting:

> [Robison] was expressly based, at least in part on the fact that if [the provision challenged in Robison] reached constitutional challenges to statutory limitations, then absolutely no judicial consideration of the issue would be available. Not only would such a restriction have been extraordinary, such that "clear and convincing" evidence would be required before we would ascribe such intent to Congress, 415 U.S. at 373, 94 S.Ct., at 1168, but it would have raised a serious constitutional question of the validity of the statute as so construed. *Id*, at 366-367, 94 S.Ct., at 1165. In the present case, the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus the plain words of the third sentence of § 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to non-constitutional claims arising under the Act. 422 U.S. at 762.

The result in *Salfi* was reached in main part because the rule expressed in *Johnson* (Congressional foreclosure of all forums in which to bring substantive constitutional claims would raise serious constitutional questions) was not violated. This Court observed that the Social Security Act did provide a forum and that the claimant was simply guilty of not making his challenges in the correct forum. In essence, this Court approved of a "jurisdictional detour" in *Salfi*—not a "jurisdictional bar."

The statutory scheme here, if interpreted as suggested by petitioner, would deny Part B providers and beneficiaries a forum to address not only constitutional challenges but regulatory and statutory challenges as well. As previously demonstrated, the carrier is specifically not empowered to address these challenges.

The present case is not a matter of whether a hearing at a meaningful time and meaningful manner is conducted. See *Armstrong* v *Manzo*, 380 U.S. 545 (1965). Rather, it is of a more rudimentary nature and concerns whether any hearing at all will be provided to regulatory, statutory or constitutional challenges addressed to the administration of a major social program—Medicare. Amicus Curiae suggest that due process mandates such a hearing and forum.

In assessing due process claims, this Court has employed a flexible scale which balances the importance of the rights at stake against the procedural rights afforded. The factors to consider were delineated by this Court in *Mathews* v *Eldridge*, 424 U.S. 319, 335 (1976):

> [O]ur prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

The application of this test to the case at bar shows that the foreclosure of all judicial review would clearly deprive respondent of their due process rights. As an assignee of Medicare benefits, respondent has an interest protected by the Due Process Clause of the Fifth and Fourteenth Amendments.[15] This Court has on previous occasions

[15] An assignee's interest in Medicare benefits is equivalent to a beneficiary's interest. See § 1395(b)(3)(B)(ii); 42 C.F.R. 405.801; *Szekely* v *Florida Medical Association*, 517 F 2d 345 (1975) *cert den* 425 U.S. 980 (1976).

"implicitly recognized" a like interest in the receipt of Social Security benefits.[16] *Richardson* v *Belcher*, 404 U.S. 78 (1971); *Richardson* v *Perales*, 402 U.S. 389 (1971); *Flemming* v *Nestor*, 363 U.S. 603 (1960).

Secondly, the risk of an erroneous deprivation of respondent's rights is exceedingly high. Where no forum to address basic regulatory, statutory or constitutional challenges is provided, grave violations can easily occur. This can be poignantly demonstrated by assuming certain factual circumstances. The Part B carrier has been delegated wholesale administration of the Medicare Program and the hearing officer is charged with applying the Secretary's guidelines to the letter. However, if no review from the carrier "fair hearing" is provided, even the Secretary's own guidelines could go unheeded. Such unbridled authority could be used arbitrarily and capriciously, either for or against the government's interest. [Indeed, there may very well be carrier determination the Secretary wishes to appeal. See *Aquavella* v *Harvey*, 615 F 2d 12 (2nd Cir 1979)]. Numerous hypothetical situations can be postulated.

If the Secretary decided to no longer reimburse for treatment of sickle cell anemia or to reimburse foreign trained physicians at a lower rate than domestically trained physicians, these flagrant violations of equal protection rights under the Fourteenth Amendment would be denied expression, in any forum. Or, if the carrier decided not to comply with the applicable regulations and refused to accord a provider or beneficiary a "fair hearing," how would that beneficiary or provider challenge this basic denial of due process?

While these facts are hypothetical, a survey of litigation which has arisen indicates that legal challenges to the administration of the Program have been made and that federal courts have found several of the challenges to be meritorious and demonstrative of violations to the U.S. Constitution.

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[16] *Mathews* v *Eldridge*, supra, at 332.

In *McClure* v *Harris*, 503 F Supp 409 (C.D. Cal., 1980), Part B beneficiaries claimed that the "fair hearing" procedures under Part B violated their rights to due process and equal protection of the law and unconstitutionally delegated judicial power to private entities. The District Court concluded that appointment of the hearing officer by the carrier was violative of due process since the hearing officer would have prior involvement in the case (since a carrier employee) and a pecuniary interest (since their incomes as hearing officers were dependent upon whether the carrier enlisted their services). The Court further concluded that the delegation of authority to the carrier's hearing officer likewise offended the requirements of due process of law.

In *Michigan Academy of Family Physicians, et al* v *Blue Cross and Blue Shield of Michigan, et al*, 502 F Supp 751, (E.D. Mich., 1980), the carrier had established certain reimbursement "screens" which entailed the separation of allopathic physicians and placement of family physicians into a "screen" including podiatrists and chiropractors for purposes of determining reasonable charges under Part B of the Medicare Program. The District Court found that this action violated the patient's choice of physician as guaranteed by the Medicare statute, §1395a, and violated §1395u(v)(3), which provides for the setting of reasonable charges according to the customary charges of physicians for similar services. Although the District Court found that because the actions of defendant violated the Medicare statute it need not consider the constitutional arguments raised by plaintiffs, the Court characterized the actions of the carrier as discriminatory, not rationally related to any legitimate purpose of the Medicare statute and defying all reason.

In *St. Jude Manor Nursing Home, Inc.* v *Richardson*, No. 72-681 (M.D. Flor., filed July 27, 1974) reported in CCH, Medicare and Medicaid Guide at New Developments, ¶ 27, 226, a Federal District Court was faced with a

regulation promulgated by the Secretary that provided that neither the insurance carrier nor the Secretary could be made a party to the administrative hearing. The beneficiary and/or provider was the *only* party required to appear. The District found the regulation violative of "minimum standards of due process" since the insurance carrier or Secretary would not be bound by any administrative order if not a party.

While these three cases demonstrate both constitutional and statutory challenges, their importance is not so much that the claimant's merits were found persuasive as the fact that a forum existed in which to make these claims. The interpretation of the previously cited statutes urged by petitioner would foreclose a judicial forum for these types of cases.

Lastly, there would be no great fiscal or administrative burden imposed by requiring that some forum for regulatory, statutory, and constitutional challenges be found. In *McClure* v *Harris, supra,* at 416, the Court considered the government's interest and stated:

> The government clearly has a strong interest in controlling the costs associated with the Part B Medicare program. However, it is far from clear that the imposition of Part A hearing procedures would entail substantial additional costs. As defendants point out, more than 124 million Part B claims were processed by carriers in 1978. Only a fraction of those claimants pursue their currently available appeal remedies (i.e., review determinations and hearings). If an appeal to the Secretary is made available, there is no indication that anything but an even smaller group of claimants will actually pursue this additional remedy. Moreover, the cost of providing such additional remedy will be minimized by the fact that the Secretary already maintains an appeal procedure, utilizing administrative law judges, for Part A claimants. To enable Part B claimants to

> appeal adverse hearing officers' decisions to Part A administrative law judges would not require the creation of a new appeals system or a new bureaucracy. It would simply increase the number of claimants who utilize the existing Part A administrative appeal. That would not be a cost-free change from the status quo, but neither should it be a costly one.

Additionally, the process of assignment also works so as to limit the total number of appeals which would be brought. As explained earlier, assignment serves to group claims and results in challenge that more typically go beyond questioning the amount to benefits for a given service.

In short, Amicus Curiae believes that to interpret the Medicare Act to foreclose judicial review for all claims made under Part B would be tantamount to making § 1395ff of the Act unconstitutional. A longstanding principle of statutory construction is to interpret statutes so as to avoid possible constitutional infractions. *United States* v *Thirty-Seven Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robinson, supra*. The availability of a meaningful forum in which to bring legal challenges is a hallmark of our notion of due process. In Justice Frankfurter's words, "The right to be heard before being condemned to suffer grievous loss of any kind . . . is a principle basic to our society." *Joint Anti-Fascist Committee* v *McGrath*, 341 U.S. 123, 168 (1951) (Frankfurter, J., concurring).

III. SUMMARY OF ARGUMENT

In order for petitioner to prevail in the within case, it must be shown by clear and convincing evidence that 42 U.S.C. §§ 1395ff and 1395ii show a legislative intent to deprive beneficiaries and providers under Part B of Medicare a forum in which to raise regulatory, statutory or constitutional challenges to the administration of the Medicare Program. Section 1395ff neither expressly grants nor expressly denies review from these sorts of challenges. Despite petitioner's best effort, Congressional silence cannot be transposed into a clear and convincing showing of Congressional intent.

The legislative history cited by petitioner is also unconvincing since that history shows no more than an intent to foreclose review of beneficiaries or providers who challenge the "amount of benefits for a given service." The Secretary of Health, Education and Welfare has interpreted § 1395ff, and its history, so as to draw a distinction between "amount of benefits" challenges on the one hand, and regulatory, statutory or constitutional challenges on the other. Under the petitioner's interpretation of § 1395ff and its history, a beneficiary or provider of services under Part B of Medicare would not only be denied an administrative forum to make regulatory, statutory or constitutional challenge, but would be denied a judicial forum as well.

Furthermore, the incorporation of § 405(h) of Title II of the Social Security Act [42 U.S.C. § 405(h)] by § 1395ii does not show clear and convincing Congressional intent to foreclose review of all Part B cases. Section 405(h) forecloses judicial review after an administrative hearing conducted by the Secretary. An administrative hearing under Part B is conducted by a hearing officer appointed by the insurance carrier who has been delegated the responsibility for the administration of Medicare-Part B.

Additionally, this Court's interpretation of § 405(h) in *Weinberger* v *Salfi*, 422 U.S. 749 (1975) does not lead to the foreclosure of review in the within case. Pursuant to §

1395ii, § 405(h) is only to be applied to the Medicare Act to the extent to which it is applicable to Title II of the Social Security Act. In *Salfi*, this Court interpreted 405(h) as foreclosing 28 U.S.C. 1331 judicial review of constitutional claims since those claims could be made in the administrative hearing provided coupled with an alternative source of judicial review. Since no such administrative forum to address constitutional claims exists under Part B of Medicare, § 405(h) should not be incorporated into the Medicare Act in such a way as to foreclose judicial review.

Secondly, if it is assumed, arguendo, that petitioner has shown Congressional intent to foreclose review, any such Congressional intent would constitute a denial of due process of law under the Fifth Amendment to the Constitution. Since the administrative hearing afforded to Part B claimants cannot address constitutional challenges to Program administration, the denial of any forum in which to address these challenges is a denial of due process of law. In balancing the rights being violated against the governments interest, it is clear that serious legal challenges to the Medicare program cannot go without a forum for expression without violating the due process rights granted by the Constitution.

CONCLUSION

For the reasons indicated, Amicus Curiae requests that this Court affirm the decision of the Court of Claims.